AN INTERPRETIVE ANALYSIS OF THE TEACHING AND LEARNING ASPECTS OF THE PRACTICE OF PRECEPTING

By

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This dissertation is dedicated to the preceptors and orientees
whose lives I was allowed to enter from
an in-depth perspective for a short period of time. The preceptors are to be admired for their work, commitment, and caring practices and the orientees are to be commended for exposing their vulnerability during their transition.
I have been indeed privileged to have this opportunity.

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Most hospitals utilize preceptors to orient nurses to new and unfamiliar organizational settings. The purpose of this study was to discover what teaching practices preceptors used to assist orientees acquire the practical knowledge and skills required for their new work environments and to facilitate the socialization process. Perspectives were obtained from both the teacher (preceptor) and learner (orientee). Research questions were grounded in literature on the practice of precepting, learning from experience, and the theory of teaching and learning pertaining to practical knowledge.

A case study approach employing qualitative methods of data collection was used. During five months of 1994, 8 preceptors and 8 orientees, who satisfied eligibility criteria, participated in 62 open ended, in-depth interviews. Interviews were conducted weekly for four weeks and focused on teaching and learning experiences. Two photographic sessions were conducted each day to capture the activities of precepting and to promote discussion during interviews.

Data were analyzed using an interpretative approach that identified common categories, themes, and patterns.

Analysis of data revealed 10 patterns and associated themes that were grouped under three categories: (a) the teaching domains of precepting, (b) the tact of precepting, and (c) the journey to independence. Teaching domains contained practices preceptors utilized to teach about basic and complex skills, organize and prioritize work, and interpret situations. The tact of precepting contained practices used to facilitate the transition of orientees into their new work environment and safeguard patients and orientees. Practices contained within the journey to independence were used to move orientees toward independent, safe practice. All described practices will add to the body of knowledge related to the practice of precepting and can be used in planning and implementing training programs for preceptors.

CHAPTER I
INTRODUCTION TO THE PROBLEM

Introduction

Hospitals are responsible to the public and accrediting agencies for ensuring that nurse employees are capable of providing safe, concerned care to their customers, their patients or clients (Joint Commission for Accreditation of Hospital Organizations, 1994). This responsibility is made even more challenging and demanding as a result of emerging health care reform and the increase in litigation. Hospitals are challenged by the government, consumers, insurance companies, the legal sector, and competitor hospitals to conduct their business in a safe, efficient and effective manner. Today, it is a matter of survival.

In any hospital organization, nurses comprise the largest portion of the work force (Bellinger & McCloskey, 1992) and at any point in time in the day the nurse may be the only person who is monitoring the status of and caring for the patient. Therefore, hiring and training staff is both an economic and quality issue. The cost of hiring and training a new nurse is estimated at $3000 to $8000 (Hinshaw, Smeltzer, & Atwood, 1987). Higher levels of knowledge and skill are directly correlated with higher quality of care. Therefore, it is essential that all nurses possess the knowledge and skill necessary to fulfill their role and responsibility to their employers and customers. Higher levels of skill acquisition, as influenced by experience, relates to the ability of nurses to detect and act upon subtle but salient factors displayed in clinical situations resulting in alleviation of crises (Benner, 1984).

Nurses receive formal education in the art and science of nursing by attending colleges, universities, or schools of nursing. During this two, three, or four-year period of time, student nurses receive both didactic and clinical education in a variety of inpatient and outpatient settings. Upon completion of the formal education program, graduate nurses may apply and be selected to work in a hospital. There they either choose or are assigned to a particular area of the hospital such as medical/surgical, operating room, obstetrics, psychiatry, or intensive care. During their careers, nurses may remain in the same setting, move from one setting to another within the same facility, move from hospital to hospital, or may work in a setting outside a hospital, such as a doctor's office, home health care, prison, or school. In different settings inside or outside the hospital, the care of patients or clients with unique problems requires distinct knowledge and skills to meet job responsibilities. In all settings, the best practice by nurses is a combination of theoretical and practical knowledge (Kramer, 1974).

When hospitals hire a new nurse or transfer a nurse from one setting to another, it is the responsibility of the employer to provide the education and training needed to ensure the safe care of patients (Joint Commission for Accreditation of Hospital Organizations, 1994). Today, in the beginning phases of training, many hospitals utilize centralized didactic orientation programs where generic information is conveyed to new nurse employees, usually in a classroom type setting (Shamian & Inhaber, 1985). Following this period, new nurses are often assigned an experienced nurse preceptor who is responsible for socializing and orienting them to their new practice environment (Holly, 1992).

A preceptorship approach for the orientation of new nurses is one of the most effective and economic ways for nurses to integrate the knowledge they acquired in school and if applicable, the experience they acquired in previous

practice into a new employment setting (Davis & Barham, 1989). A preceptorship is a one to one teaching/learning experience where an experienced staff nurse is assigned to acquaint a new nurse to role expectations and responsibilities and organizational values (Bellinger & McCloskey, 1992). Preceptorships take place in the actual practice setting and an experienced staff nurse preceptor acts as teacher, supervisor, guide, coach, and role model for the new nurse (Peirce, 1991). Preceptors usually attend short training sessions to prepare themselves for their responsibilities and assume teaching responsibilities in addition to their regular duties of caring for patients (Alspach, 1989a).

The practice of precepting involves a unique and complex relationship between the preceptor and orientee with interactions and goals directed to teaching and learning (Armitage & Bumard, 1991). Many variables are involved in the process of precepting such as learning styles, previous experiences, personality, and level of knowledge (Carroll, 1992). These variables are intertwined into the total picture of a person, rather than individual components that can be separated and looked at as individual entities. Another factor adding to the complexity is the fact that precepting is conducted on a nursing unit amidst the many interruptions and unforeseen occurrences that are present in a busy hospital setting. Therefore, teaching and learning must be flexible and occur in many non-conventional, unexplained ways and modifications are frequently made to fit the ever changing environment (Holly, 1992).

Descriptive and research based literature on the practice and benefits of precepting is abundant. However, no studies have looked at the practice of precepting from a teacher and learner perspective. Because there are no studies of the preceptor as teacher and new nurse as learner, training for preceptors is based on what is thought to be important (Holly, 1992). Topics frequently included are assessment of learning needs, adult learning principles, reality

shock, role and responsibility of the preceptor, and principles of teaching and learning (Alspach, 1989a). However, lack of information about how the practice of precepting actually occurs causes limitations in planning and implementing preceptor training programs. Specific guidelines for teaching and learning can only be hypothesized.

Teaching, whether it be in a practice setting or in an academic setting, is practical work based on a combination of theoretical and practical knowledge (Britzman, 1991). Practical knowledge is required to deal with situations that cannot be handled by theoretical knowledge alone (Schön, 1983). Description and interpretation are a research approach towards understanding practical teaching experiences in the place where they occur (Britzman, 1991), including the practice of precepting. In the practicing hospital environment, the teacher of new nurses (preceptor) works with new nurses (orientees) who are unfamiliar with their newly assigned setting, whether they are new graduates or experienced nurses new to an area. The goal of the preceptor program is to facilitate the transfer of what orientees learned in school (theoretical knowledge) and in previous jobs (practical knowledge) to their new setting under the guidance and experience of their teacher. Studying this process provides a mechanism for understanding how people learn in an informal work environment through their experiences (Lovin, 1992) and is the focus of this study.

Statement of the Problem

The problem addressed in this study is the lack of knowledge about the teaching and learning aspects of the practice of precepting. The goal of the study is to uncover the lived teaching and learning experiences of preceptors and orientees and describe them as they occur in the natural hospital setting. This is an important and fundamental issue because the majority of nurses work in

hospitals and preceptor programs are widely employed by hospitals as a mechanism for socializing new nurses to their newly assigned areas.

The problem addressed in this study has two domains, that of the teacher and that of the learner. As teacher, the preceptor assumes the dual role of caring for patients and orienting a new employee (Holly, 1992). This dual responsibility increases the complexity of the role and may require unconventional ways of teaching that are unknown. How the preceptor is able to incorporate work into the realm of teaching is a question that has not been answered and one where understanding can have great value for other preceptors, educators, and the nursing profession. The study is also important from the perspective of the learner, the new nurse. Since learning is an internal process, professionals should be encouraged to reflect on their personal perceptions of meaning related to experiences (Baskett, Marsick, & Cervero, 1992). By reflecting on the process of learning, new nurses can provide insight into what they feel is effective teaching and what enhances their learning. How orientees respond to teaching experiences will provide insight into their lived experience that can help to construct a model that can be passed on to others.

Importance of the Study

This study is important for several reasons. First, the study provided insight into the experiences of preceptors and orientees as they went through the process of teaching and learning combined with other responsibilities. This was the first study to investigate the teaching and learning aspects of precepting within the hospital environment from the perspective of both the preceptor and orientee. Other studies and descriptive reports have validated that precepting is widely used and can benefit new nurses, hospitals, and preceptors (Shamian & Inhaber, 1985), but none have addressed the aspects of the practice of preceptors, that of teaching in an organizational setting (Andersen, 1991a). The

importance of the question increases when consideration is given to the complexity of the responsibility and the limited training that most preceptors are provided. A majority of hospitals provide only eight to 16 hours of training (Shamian & Inhaber, 1985). As a result of role complexity and limited education about how to teach new nurses, surveyed preceptors reported being most comfortable with clinical role modeling, a role they portray every day, and least comfortable with the roles of educator and socializer (Alspach, 1989b). Second, the study was useful for planning and implementing preceptor training programs. Understanding how the actual practice of teaching occurs in the work setting will be of great benefit to those who provide such programs. Understanding how people learn in their practice setting is important so that they can be assisted to achieve successful learning outcomes (Brookfield, 1985).

Finally, this study is important from a learner perspective. The orientation period is one of stress and role confusion. If socialization to a new work setting is not facilitated in a positive manner, frustration and dissatisfaction can result that can affect the decision of whether to remain an employee of the hospital organization (Kramer, 1974). Since orienting a new nurse is costly, it behooves hospitals to provide programs that will enhance retention (Hinshaw, Smeltzer, & Atwood, 1987).

Purpose and Objectives of the Study

This study was designed to discover the process of precepting as it occurred from the perspectives of both the preceptor (teacher) and orientee (learner). The study was aimed at understanding the practice of precepting, understanding the situations in which the practices are carried out, and with understanding, to improve practice (Kemmis & McTaggart, 1988). The following research questions guided data collection in this study:

1. What teaching/learning experiences do orientees identify that assist role transition and socialization to a new work community?

2. What teaching/learning experiences do orientees identify that assist in development of basic knowledge and skills in a new health care environment?

3. What teaching behaviors and activities do preceptors use to facilitate the learning process of nurse orientees?

4. What strategies do preceptors use to reduce the stress associated with role transition of orientation into a new work environment?

5. How do preceptors handle their work and teaching responsibilities simultaneously?

Rationale of the Study

Preceptor programs, as a mechanism for orienting new nurses, have been used in hospital settings since the 1960s (Peirce, 1991). Programs are designed to bridge the theory-practice gap that exists both with new graduates and experienced nurses who move to unfamiliar areas of practice (Armitage & Burnard, 1991). The orientation period is an uncomfortable, stressful period for new employees, but important to the organization. During this vulnerable period, a lasting impression of the work setting is formed that influences retention and turnover (Hinshaw, Smeltzer & Atwood, 1987; McLean, 1987).

Nursing literature citing the benefits of preceptor programs for hospitals, orienting nurses and preceptors is abundant (Bellinger & McCloskey, 1992; Flewellyn & Gosnell, 1987; Giles & Moran, 1989; Hamilton et al., 1989; Hitchings, 1989). Other studies have reported benefit to senior nursing students (Clayton, Broome, & Ellis, 1989; Dobbs, 1988; Ferguson & Calder, 1993; Scheetz, 1989). Most articles, however, are descriptive and few studies are supported by research (Bellinger & McCloskey, 1992). Not all studies evaluating preceptor programs have resulted in positive outcomes. Anderson (1991a)

examined the effect of preceptorship programs on senior students in relationship to moral reasoning. Results revealed that preceptors emphasized bureaucratic functions such as documentation more than the professional role of providing patient care.

Only two studies were located that focused on the teaching and learning aspects of precepting. Andersen (1991b) analyzed student logs and evaluation forms to describe specific instructional strategies preceptors used to teach senior students the role of the staff nurse. Specific teaching skills identified included demonstration, return demonstration, coaching, role modeling, time management, and dialogue. A weakness of this study was that the researcher utilized information from students to identify what preceptors were doing, rather than from preceptors or both. Rittman (1992) used an interpretative approach to analyze preceptor narratives that described experiences with new nurses and students. Narrative analyses revealed the influences that previous learning experiences had on teaching, the broad range of skill required for preceptors, and the importance of timing in the practice of precepting. No studies were found that focused on the teaching and learning perspective of both the preceptor and orientee in a hospital setting.

Lack of inquiry into this area means that training of preceptors is focused on general education principles, such as adult learning, rather than on practical models that may be successful in actual work settings. In fact, actual teaching practices of precepting are not recorded and cannot be used to guide others in practice with conviction.

The role of preceptor in a practice setting means that work is combined with teaching. Assigned patients must be cared for at the same time that orientation is occurring. Therefore, working along side the new nurse becomes a form of teaching and increases the complexity of the situation. What techniques

are used by the teacher and how meaningful these techniques are, as perceived from the learner, are unknown. This study is important to make known how positive learning outcomes are achieved in a way that is not only efficient and effective, but ensures that standards of practice are achieved in such a manner as to encourage retention of both the learner and teacher.

The investigator of this research study became interested in the teaching and learning aspects of precepting after dealing with the complexity of the process for many years and finding a lack of research-based literature on the topic. Not only is there a need to understand the intricacies of the practice of precepting in the work setting, but to understand it from the perspective of the teacher and learner in the natural setting.

Definition of Terms

Orientation is a program designed to introduce nurses who change role and responsibility to the philosophy, goals, standards, and procedures necessary to work in a new setting (American Nurses Association, 1978).

An orientee is a graduate or registered nurse, recently hired or reassigned to an unfamiliar setting, and assigned to a particular preceptor in order to experience day to day practice with a role model and knowledge resource (Armitage & Bumard, 1991).

A preceptor is a peer registered nurse who is responsible for the orientation of a new nurse (orientee) to a particular unit , in addition to regular duties, for a limited time period (Bellinger & McCloskey, 1992; Peirce, 1991).

A preceptorship program is a structured one to one teaching/learning strategy designed to orient and ease the transition for nurses who are entering the professional role for the first time or who are in a new position. (Bellinger & McCloskey, 1992; Holly, 1992).

Socialization is the process, facilitated by a preceptor, through which an orientee acquires the knowledge, skills, and sense of identity characteristic of other staff nurses (Clayton, Broome, & Ellis, 1989).

Delimitations of the Study

The study was delimited to one government hospital in North Central Florida. Subjects in the study were 16 graduate or registered nurse employees of the government hospital, eight of whom were in the roles of preceptor and eight in the role of orientee. Fifteen subjects were female and one was male with a range in age from 23 to 54 years. Sampling was purposive and subjects were selected by the investigator in collaboration with the expert judgment of head nurses on the basis of who would provide the most insight into the research questions. Therefore, there was no random sampling or matching and no consideration for sex, nursing education, nursing experience, or age. In addition, the study was conducted during the first four weeks of the orientation period. This period did not comprise the entire preceptorship program, however, comprised the period when intensive teaching and learning were occurring.

Limitations of the Study

Data in this study were collected using qualitative observation and interviewing techniques in a natural setting. Therefore, transferring results to other sites and populations will be limited by the qualitative method. Any attempt to transfer findings beyond the contexts of those studied should be appraised by investigators as to relevancy and similarity. Reference should be made to the theoretical framework upon which the study was based. Specific methodological constraints are described in Chapter III.

Summary

Hospitals utilize preceptors to orient new nurse employees to their newly assigned settings. Preceptors fulfill the role of teacher by facilitating the transfer

of previously learned knowledge and acquisition of new knowledge and skills to ensure the safe care of patients. The process of teaching and learning during the precepting experience was the focus of this study. The practical aspects of teaching in an informal setting and the impact on the learner were observed through photographs and interviews. The goal was to discover and understand the teaching and learning process involved in the practice of precepting that will contribute to knowledge related to teaching/learning in practice disciplines such as nursing.

Chapter II presents a review of pertinent literature related to the history and practice of precepting, the concept of teaching and learning from experience, the enhancement of experience through action and reflection, and the components of practical knowledge. In Chapter III the methods and procedures used in this research are described. Chapters IV, V, VI, and VII contain results of the study and Chapter VIII contains discussion, conclusions and suggestions for further research.

CHAPTER II
REVIEW OF THE LITERATURE

Chapter II will present a review of research related to the practice of precepting from both the teacher (preceptor) and learner (new nurse/orientee) perspective. The chapter will review relevant professional literature related to the history of precepting, the practice of precepting, teaching and learning principles involved in precepting, and research that has evaluated the effect of preceptor programs. In addition and to provide a theoretical framework for teaching and learning aspects of precepting, the chapter will review professional literature pertaining to education in the organizational or experiential setting. Included will be the impact of experience on learning and professional development, learning models and teaching techniques utilized in experiential settings, and components of and methods for enhancing practical knowledge.

Introduction

Hospitals continually hire new nurses who are unfamiliar with the setting in which they will be working. All nurses receive formal academic education and may have experience in different hospital settings, but each hospital and even each area of a hospital has unique cultures, practices, requirements, and standards and as a result the need for education and training is great. On-site education and training is the responsibility of the hiring organization and is required by accrediting agencies to ensure that safe patient care will be provided (Joint Commission for Accreditation of Hospital Organizations, 1994).

Adaptation to a new, unfamiliar environment can be fraught with anxiety, fear, frustration, problems of adjustment, and crisis (Allanach & Jennings, 1990;

Doherty, 1988). This is particularly true in nursing where on a daily basis life and death situations may be encountered by nurses. Regardless of the knowledge or experience of the nurse, the expectation of the public is that nurses will recognize when a patient is in trouble and know what to do. Therefore, "what is learned should not be left to random happenstance" (Bishop & Whitman, 1991, p. 426).

When nurses accept a new job, they arrive at the workplace with the question, "How should I act?" and "What do I have to do and know?" In practice, nurses' responses to situations are primarily related to doing something. And "while doing is best accomplished in the presence of knowing ... it is the taking of action that is the fundamental characteristic" of practice (Short, 1991, p.11). As mentioned, all registered nurses complete a formal academic program and pass a nationwide administered certifying examination in order to qualify for licensure. Most new graduate employees finish school well educated in theory, but lack the skills that are valued by nursing services and required to cope with the day-to-day situations (Clayton, Broome, & Ellis, 1989). Therefore, the need to know requirement is not as much one of theoretical knowledge as one of practical knowledge and skill. Exceptions occur when the area of assignment requires a knowledge base that is not a part of traditional academic programs, such as intensive care and operating room. In those instances additional theory is required. Thus the work of organizations becomes one of teaching the new nurse how to apply theoretical knowledge to the job of caring for patients within the assigned work environment, such as oncology, cardiothoracic surgery, general surgery, or general medicine.

There are several formats that hospitals use to provide education and training to new employees in an unfamiliar setting. Today, in the beginning phase of employment, most hospitals utilize centralized orientation programs conducted by the education department where generic information is conveyed to

new nurse employees, usually in a classroom type setting. During this centralized educational period, new nurses are introduced to overall hospital policy, procedure, and philosophy (Shamian & Inhaber, 1985). Sessions extend from one day to several weeks. Following this period, new nurses receive some form of introduction to the area where they will be practicing. This "on the job training" can be accomplished by trial and error or can be guided by the supervisor of the area, different nurses assigned to a new nurse on different days, or one assigned staff nurse who functions as a preceptor for the new nurse. During recent years, the decentralized preceptor model of unit orientation has become recognized as an effective means of bridging the gap between knowledge and practice and reducing the stress associated with adjustment to a new environment (Shamian & Inhaber, 1985).

Preceptor Programs

The History of Precepting

The concept of using experienced nurses as preceptors to orient new nurses began in the 1960s. Prior to this period, most students received their education and training in hospital based schools of nursing that focused on clinical rotations (Myrick, 1988). Student nurses received many hours of clinical experience, caring for patients in a variety of settings such as pediatrics, obstetrics, operating room, and medical/surgical. Upon graduation, new graduates were able to acclimate fairly easily to new hospital settings since their education and training closely resembled the real working world. However, in the 1960s, a condensed two-year associate degree program emerged; three-year hospital-based diploma schools of nursing, which focused heavily on clinical experiences, diminished in numbers; and four-year baccalaureate programs increased didactic content at the expense of clinical rotations. As a result, tensions developed between service and academia as new graduates expressed

frustration and difficulty in adjusting to the work setting. Health care organizations complained that new employees were incapable of assuming patient care responsibilities, and academicians complained that organizations expected too much of new graduates (Holly, 1992; Myrick, 1988).

Faced with the responsibility of ensuring that all nurses were competent to provide safe patient care, hospitals responded by developing preceptor programs, an individualized teaching/learning experience. These programs quickly became popular and have served to meet the needs of both service and academia. Today, preceptor programs are not only utilized in most hospital settings for newly employed nurses, nurses transitioning from one position to another, and for cross training nurses (Metzger, 1986), but many universities and junior colleges of nursing have also chosen this method to provide practicum or internship experiences for senior year and graduate nursing students (Davis & Barham, 1989; Scheetz, 1989; Shah & Polifroni, 1992). In terms of the nursing literature, the term preceptor first appeared as a classification on the International Nursing Index in 1975. In 1994, 38 references were listed under precepting in the Nursing Indices.

The findings of Kramer (1974) and later Kramer and Schmalenberg (1977) and Schmalenberg and Kramer (1979) on reality shock were major incentives to the formation of preceptor programs. The authors identified reality shock or biculturalism as the helplessness, powerlessness, frustration, and dissatisfaction that new graduates experience as they move from the familiar subculture of school where values emphasizing holistic, individualized patient care and family involvement are stressed to the unfamiliar subculture of work where patient safety, organization, efficiency, responsibility, and cooperation are emphasized (Schmalenberg & Kramer, 1979, p. 1). The authors described reality shock as occurring in four phases: (a) moral outrage, the responses expressed when new

graduates realized that values learned in school were not recognized in the workplace as important; (b) rejection, where the new graduate either rejected schooling or the work place in response to the realization that one or the other did not meet expectations; (c) fatigue, the physiological response to the stress of adjustment and frustration; and (d) perceptual distortion, where the new graduate became globally negative and labeled everything as bad. In response to reality shock, the authors described many pathways new nurses chose for recovery and resolution, many of which were expensive and/or nonproductive for hospitals. Some nurses renounced work values and returned to school, others job-hopped from hospital to hospital looking for "greener grass", others threw away their school values and adopted those of the work place, some stopped working or left nursing, others remained in the work place but developed attitudes that were counterproductive to teamwork and efficiency such as working their eight hours and going home, doing only the minimum, or became chronic complainers. A few chose to remain in the hospital and fight the system, holding on to the values they personally identified with (Schmalenberg & Kramer, 1979).

Other researchers also recognized problems encountered as individuals transitioned from one role to another. Meleis (1975) described role insufficiency as the anxiety, hostility, and depression that can develop as individuals are required to acquire new knowledge, change behavior, and change their place in society. As a result, crisis may result when orienting nurses cross the threshold from the familiar to the unfamiliar. To decrease the effect of this process, the author recommended role clarification, role modeling, communication, role rehearsal, and a reference group.

In response to and realizing the reality of the findings of researchers, hospitals looked for ways to minimize the stress and frustration of the transition of

nurses from school to practice and to decrease the turnover created by dissatisfaction. The development of preceptor programs was one such method.

The Practice of Precepting

The term preceptor originated in 15th century England where it referred to a tutor or instructor (Peirce, 1991). Preceptor programs, also referred to as a buddy system, internship, apprenticeship, or fellowship, assign a professional registered nurse (RN) usually with at least one year of clinical experience in the practice setting, on a one-to-one basis, to teach new employees the duties specific to their new work environment in addition to regular or modified duties. In most settings, preceptors are selected by their head nurse and/or education department on the basis of years of experience, leadership and communication skills, decision-making ability, and interest in professional growth (Shamian & Inhaber, 1985). The preceptor functions as a teacher, observer, and evaluator working directly with the new nurse providing didactic direction, demonstrating and role modeling skills required for the job, supervising, providing feedback regarding patient care, counseling, inspiring, socializing to the new culture, and acting as backup when it is realized that additional experience is needed to handle the situation (Bizek & Oermann, 1990; deBlois, 1991; Doherty, 1988; Holly, 1992). In some settings the preceptor also evaluates aspects of the new nurse's performance (deBlois, 1991).

The use of preceptors "is based on the androgogical premise that a one to one relationship facilitates effective learning" (Clayton, Broome, & Ellis, 1989, p.73). Although role and responsibility of preceptors is broad and significant, in many hospital settings, role descriptions are not written, nor well defined (Alspach, 1989a; Cantwell et al., 1989). In turn, through observation and verbal and nonverbal clues, the orienting nurse acquires the knowledge and skill needed to care for a specific group of patients and learns the nurses' role and

responsibility related to the functioning of the assigned unit (Bizek & Oermann, 1990). If the orienting employee is a new graduate, a change in role identity also occurs, "from student to professional, from student status to employee status, from reactive problem solver to proactive problem solver" (Hamilton et al., 1989, p. 160). The goal of preceptor programs is to move new nurses from novice status to a level where they can safely care for patients and feel a sense of belonging and commitment (Vogt et al., 1983). Therefore, it is not necessary for preceptors to teach new nurses everything, but rather to select knowledge and activities that will result in safe practice within a particular setting. The period allocated for precepting new nurses is time limited and usually established according to the complexity of the patient population, or it can be adapted according to individual needs and prior experiences (Doherty, 1988; Hill & Lowenstein, 1992). A survey of 35 hospitals in the Philadelphia area identified a range of two to 24 weeks, with a mean of 8.2 weeks and a mode of 6 weeks (Cantwell et al., 1989). During the initial period of precepting the orientee and preceptor work closely together. After the first few weeks, the orientee works more independently and the preceptor primarily serves as a backup when difficult or unexpected situation arise.

Preceptor programs vary from hospital to hospital. In some settings preceptor programs are outlined and structured and preceptors establish goals and objectives with new nurses and evaluate progress based on outcomes (Hill & Lowenstein, 1992; Miller & Brosovich, 1991; Shamian & Inhaber, 1985). In other settings programs are less structured and events may be based on what is occurring on any given day. In reality, programs are probably a combination of structured and unstructured formats.

Because of their success, preceptor programs are now widely accepted and are reported to benefit new nurses, organizations, and preceptors.

Advantages reported for new nurses include a smoother, quicker, less frustrating, more secure transition to a new setting, the ability to gradually learn new skills under the direction of an experienced nurse, an individualized learning experience, and the opportunity to receive immediate feedback. Hospitals can use preceptor programs not only as a recruitment device but to decrease costly orientation time, to improve staff turnover, and to maximize use of nursing education staff. Preceptors report enhancement of professional growth by being professionally challenged, motivated, and stimulated which result in increased job satisfaction. Being a preceptor also provides a means for recognition and reward. (Bizek & Oermann, 1990; Dandrines-Smith & Bower, 1989; deBlois, 1991; Hitchings, 1989; Miller & Brosovich, 1991). Identified dissatisfiers included the limited amount of time head nurses spent with preceptors and new nurses, lack of peer support for and understanding of the preceptor program and role, inadequate time to fulfill preceptor and patient care responsibilities simultaneously, and lack of formulation of mutual goals between preceptors and new nurses (Young, Theriault, & Collins, 1989).

Teaching and Learning Aspects of Preceptor Programs

The practice of precepting is reported to work but how it works is unknown. Although there is an abundance of literature on preceptor selection (Bizek & Oermann, 1990; Shamian & Inhaber, 1985), on the benefits of preceptor programs (Bizek & Oermann, 1990), on suggestions for preceptor training (Ferris, 1988; Holly, 1992; Westra & Graziano, 1992), and on guidelines for conducting preceptor programs (Mooney, Diver, & Schnackel, 1988; Shaffer & Ward, 1990), the literature on how the process of precepting actually occurs from a teaching learning perspective is limited. Lack of information in this area causes difficulties in planning and implementing preceptor training programs. Specific guidelines for teaching and learning can only be hypothesized and are

not based on actual practice. Therefore, preceptor educational programs are based on knowledge and skills that preceptors are thought to require rather than on how preceptors use knowledge and skill to guide them in their practice.

The preceptor model is based on one of the oldest teaching/learning concepts of a novice/apprentice learning at the side of a master. This form of experiential learning, is based on the ancient Chinese proverb, "I hear and I forget, I see and I remember, I do and I understand." Experiential types of education actively involve participants in the learning process and responsibility for learning is placed on the individual (Dudley & Permaul, 1984). Experiential learning is multidimensional and encourages the learner to apply knowledge gained in academic settings into a fluid, constantly changing reality setting. This type of learning contrasts with traditional or convential classroom education that focuses on knowledge and skill learned in a fixed environment (Vogt et al., 1983). The learner comes in direct contact with a phenomenon that has been studied rather than imagining an encounter or considering doing something with the information (Keeton & Tate, 1978). As a result, learners develop their own systems of handling situations through experience and are able to apply these experiences to future situations.

According to Ferris (1988), most staff nurses who function as preceptors lack training in adult education and the majority of preceptors "rely on instinct, common sense, recollections of past teacher models, and a little prayer and luck to see them through" (p.28). Teaching/learning methods that are suggested include role modeling, support, demonstration, dialogue, coaching, self assessment, feedback, and thinking out loud (Andersen, 1991b; Holly, 1992). Andersen (1991b) examined the experiences of senior students assigned to preceptors for a four week period by descriptively analyzing student logs, discussions during weekly seminars, and evaluation forms. Results showed that

preceptors utilized teaching/learning techniques such as demonstration/return demonstration, explanation, teaching brevity and shortcuts, coaching through complex skills, utilizing humor, and storytelling. In the course of their learning, students were taught to set priorities, refine skills, and anticipate problems. Although the study offers insight into teaching and learning, only the learners' perspective was analyzed within the protected academic setting. No data were gathered from preceptors. Rittman (1992), using an interpretative approach, analyzed preceptor narratives that described experiences with precepting students and staff nurses and identified skills that were important in precepting such as clinical expertise, management skills, knowing when to take over, and teaching ability. She concluded that narratives were a means of uncovering the practices of preceptors from an "inside out" approach (p. 370). In another qualitative study, Davis, Sawin, and Dunn (1993) examined the teaching strategies of expert nurse practitioners utilized in precepting other advanced practice nurses. Four patterns of teaching stategies were revealed including orientation strategies, ongoing strategies across various levels of learners, differentiated strategies between new and experienced nurse practitioners, and "letting go" strategies (p.30). Each pattern contained several themes that provided insight into how orientation was conducted for advanced level nurses. However, in this study no input was obtained from learners.

Teaching as a Preceptor

Teaching, whether it be in a practice setting or in an academic setting, is practical work. It involves acting in a certain way in order to produce desired outcomes, even though the outcomes of the action can never be fully known in advance. Teaching is fluid and interactive. Teaching establishes an environment that influences leaming. (Sanders & McCutcheon, 1986). In the hospital environment, the teacher of new nurses (preceptor) works with nurses who are

unfamiliar with their newly assigned setting, whether they be new graduates or experienced nurses new to an area. These orientees are not able to perceive important features of new or unfamiliar situations and therefore are not able to choose actions in advance that are appropriate to produce desired outcomes. Practical knowledge is required to deal with situations that cannot be handled by knowledge alone (Schön, 1983).

The teaching required to impart this practical knowledge is also practical in nature and is not only based on scientific theory, but on wisdom, experience, and practice centered inquiry (Atkin, 1992; Sanders & McCutcheon, 1986). Theories of teaching are believed to be practical because they are specific to instances of a given kind, developed individually, refined by experience, and enable decision making in concrete situations (Atkin, 1992). Through their experience, teachers discover what it takes to be effective and produce desired outcomes. They accomplish this through self-reflection, observation of others, dialogue, and observation of outcomes. Sanders & McCutcheon (1986) suspect that individual teaching actions are not acquired by teachers, but rather developed through a process of conceptual and empirical testing, reflection, and decision making as to whether to use, to modify, or to not use an action.

Because of the paucity of research in the nursing literature on the actual practice of preceptor as teacher, selected education literature on teaching as practical knowledge was reviewed to provide a framework for this study. Elbaz (1981) used a qualitative case study approach to consider how teachers in the school setting apply theory to practice. The researcher used interviewing and observation to study the ways in which knowledge was acquired and held by an experienced teacher. Three themes emerged from the research: rule of practice, practical principle, and image. The rule of practice was a highly specialized statement "... of what to do or how to do it in a particular situation

frequently encountered in practice" (p.61). Rules of practice were used to achieve the teacher's purpose in a methodological manner, but were not always realized or articulated. For example, the researcher observed the teacher dealing with a student who frequently interrupted in a consistent, specific manner. Practical principles represented broader guidelines that resulted from deliberation and reflection on past experiences with application on current problems. Images were defined as metaphors of how teaching should be conducted and were derived from individual teacher values, emotions, and beliefs and substantiated by theoretical knowledge and non-scientific anecdotes. An example of an image would be listening to students without making a judgment. Elbaz concluded that practical knowledge is a dynamic process that lends itself to further research as to how teachers view and are influenced by theory as well as to explore various cognitive styles that will help to identify different methods of effective teaching.

Preceptor Preparation for Teaching

To prepare preceptors for their teaching role, most hospitals provide the equivalent of eight to 16 hours of training taught by clinical educators or senior nurses (Shamian & Inhaber, 1985). Training topics include role description and expectation, assessment of needs, principles of adult learning and teaching/learning, counseling techniques, positive/negative feedback, conflict resolution, evaluation techniques, and reality shock (Alspach, 1989a; Meng & Conti, 1995; Metzger, 1986; Shamian & Inhaber, 1985). Thus, just as preceptors are expected to assist as orienting nurses apply learned theory to practice, preceptors as teachers are also expected to apply what they know about teaching and nursing to the practical setting. And as the preparation for precepting is limited, the knowledge that preceptors have in regard to teaching is assumed to be derived from practice. Alspach's (1989b) survey of 351 preceptors in specialized care settings revealed that while 55% of respondents

felt *most* comfortable with role modeling patient care, only 25% felt *most* comfortable with their teaching role.

How is it then, that preceptors, who lack extensive and intensive theory of teaching, but who are schooled in the theory of nursing, function as teachers? Is it accumulated knowledge that is personally gained from dealing with everyday working and teaching situations that produces a sense of certainty about teaching others to safely care for ill patients? The preceptor, who oversees the period of practical learning while ensuring the safety of patients, becomes the link between the patient and the new nurse. Understanding the process of how new nurses learn and change behavior and how the process is facilitated by a preceptor/teacher is the focus of this research study.

Evaluation of Preceptor Programs

Although preceptor programs are widely utilized, the literature is mostly descriptive and research related to outcomes is scarce (Cantwell et al. 1989; Hamilton et al., 1989) . Not only are research studies scarce, but many hospitals do not evaluate their own preceptor programs. Cantwell et al. (1989) surveyed 35 hospitals in the greater Philadelphia area and determined that only 43% evaluated their programs either informally or by questionnaire. Variables used in evaluation included job performance of orienting nurses, retention, and an outcome audit. They also found little evaluation in nursing literature. As a result, the authors suggested that hospital educators systematically evaluate their programs in order to make changes based on factual data. For the purpose of this study, literature related to preceptorships for senior students and new hospital employees will be reviewed.

Scheetz (1989) evaluated the effect of a preceptorship on 72 BSN students in the summer between their junior and senior year in terms of gains in three domains of clinical competence and perceived preference of their

experience. Students assigned to an RN preceptor for 10-12 weeks (n=32) were compared to a control group employed as nursing assistants (n=32). Clinical competence was defined as "the ability to utilize the problem-solving process, apply theory to practice, and perform psychomotor skills" (p.30) and was measured pre- and post-treatment by the researcher developed Clinical Competence Rating Scale. The Rating Scale was administered by head nurses on assigned units. Data revealed significant gains in the three domains of clinical competence for the treatment group. Both groups reported favorable perceptions of the experience. An interesting finding was that control subjects developed a preceptor-like relationship with one or more staff nurses on their assigned units in a natural rather than assigned sense. The researchers concluded that because of the extrinsic and intrinsic reward system granted to assigned preceptors by the organization, the quality and quantity of feedback, supervision, and assistance may have been less in the informal situations resulting in less gain in competence.

Clayton, Broome, and Ellis (1989) evaluated the effect of a preceptorship on the professional socialization behaviors of BSN graduates. Subjects consisted of 66 senior students, half of whom were assigned one-to-one with a staff nurse preceptor for 10 weeks and half of whom were guided as small groups through the practicum experience by a faculty member. Both groups completed the Schwerian Six Dimension Scale of Nursing Performance instrument pre-experience, immediately after the experience, and six months after graduation. The instruments measured six subscales: leadership, critical care, teaching/collaboration, planning/evaluation, interpersonal relations and communication, and professional development. Results from the study revealed (a) no significant differences between groups prior to the experiences and (b) significant differences in favor of the precepted group at six months in all

elements except professional development and critical care. In terms of role transition, findings supported the preceptor model of working with a practicing nurse in preference to working with a faculty member during the practicum experience of the senior year.

A study by Dobbs (1988) also supported the senior year preceptorship for BSN students. Students (n=103) enrolled in an eight week practicum experience were assigned an RN preceptor with at least one year of work experience. Perceptions, values, and esteem of role models were measured by Corwin's Nursing Role Conception Scale pre and post experience. There were significant decreases between pre and post scores indicating students had learned to cope with demands of the clinical role under the guidance of a preceptor. The study also demonstrated that students who changed role models whom they held in high regard, from school centered to work centered, had a greater significant decrease between scores than those who remained school centered or had no role model.

Dunlevy and Wolf's (1992) review of the literature found little evaluation of clinical precepting for all allied health/medical educational programs. And although some studies had identified teaching behaviors, none gave suggestions for implementing the behaviors. Therefore, the authors conducted a study where 102 students and 90 preceptors from the disciplines of physical therapy, respiratory therapy, coordinated dietetics, and medical technology were surveyed to compare perceived importance of 43 identified clinical teaching behaviors utilized by preceptors to perceived frequency of use. Subjects were administered the Effective Clinical Teaching Behavior scale at two intervals. During the first round of survey, subjects were asked to indicate the importance of behaviors used by preceptors during clinical rotations. During the second round, subjects were asked how frequently behaviors actually occurred. Students and

preceptors agreed on individual behavior importance 96% of the time, however, there were significant differences related to frequency of 65% of behaviors. Thirteen behaviors were considered important by preceptors, but reported as only occasionally or never practiced. Behaviors with the highest disagreement were communication skills, tolerance, and availability. Thus, there was disparity between what preceptors identified as important clinical teaching behaviors and their actual practice as perceived by both themselves and their students.

Other studies have resulted in varying results. Bellinger and McCloskey (1992) found few significant differences in the areas of satisfaction, social integration, turnover, and performance between nurses oriented with and without preceptors. They concluded, however, that preceptors are beneficial for nurses with less education and experience and in areas where sicker patients are cared for.

In summary, research studies have focused more on the impact of precepting senior students than on practicing nurses and have focused on socialization and transition of new nurses. Few studies have approached the evaluation of preceptor programs from a teaching and learning perspective to determine how teaching behaviors are implemented and how learners respond.

Learning Outside the Classroom

Precepting belongs to a group of learning experiences that occur outside the formal, institution-based classroom yet within the confines of an organizational setting. This type of learning has been designated by many names including learning from experience, learning by doing, practical learning, professional learning, continuous learning, informal learning, and learning within the workplace (Baskett, Marsick & Cervero, 1992; Marsick, 1987; Watkins & Marsick, 1992). Advocates of this type of learning are more concerned with what people learn in terms of knowledge and skill outcomes and less concerned with

how people learn (Kolb, 1984). And although some learning within the workplace can include more traditional forms of education, because of rapidly advancing technology and role sophistication, most organizations, including hospitals, have found that traditional learning alone is not sufficient to make and keep employees functional in order to meet business and customer needs (Watkins & Marsick, 1992). Learning in the workplace can be planned or unplanned, but it is intentional learning and is recognized as such by both teacher and learner. While past educational studies focused mainly on traditional learning, more recent writings and research have begun to explore learning within the workplace (Jarvis, 1987, 1992a; Kolb, 1984; Mezirow, 1981; Schön, 1983).

Learning in the workplace or informal learning differs from formal, traditional classroom learning in several ways. The formal learning method has a theoretical or scientific orientation and is predominant within academic classrooms. This traditional orientation focuses on acquisition of observable skills as a level of competency that are believed to be desirable for a professional. The source of knowledge is based on research and serves as a foundation for practice. Learning is mainly an individual passive process and the learner has little input into objective development as knowledge and skill are prespecified and measured by the level of competency achieved (Stevenson, 1993). Questions from learners are answered from information derived from scientific writings and research. This information usually excludes the practical knowledge of those who work in the situation where the problem exists or applies.

Informal learning, on the other hand, predominates within businesses and organizations and involves many kinds of learning that are grounded in experience (Watkins & Marsick, 1992). Informal learning usually involves adult learners as both teachers and learners and content areas can be either (a)

chosen by an individual to gain or retain knowledge or skill (Tough, 1979), (b) dictated by the needs of organizations and/or their customers, or (c) an unexpected occurrence that results from an encounter with a person or event (Watkins & Marsick, 1992). "Strategies for informal learning include self-directed learning, networking, coaching, mentoring, performance planning systems that are used for developmental purposes and trial-and-error" (Watkins & Marsick, 1992, p.291). Whereas the emphasis in formal learning is on individual learners, informal learning often focuses on teams within the social context of the workplace culture that is dictated by rules, policies, traditions, and work or professional standards. Watkins and Marsick (1992) have identified seven elements critical to the conceptual understanding of informal learning: learning from experience, organizational context, a focus on action, non-routine vs. routine conditions, the tacit dimension of knowledge, delimiters to learning, and enhancers of learning. For the purpose of this research study, the elements of learning from experience, a focus on action, and the tacit dimension of knowledge will be explored.

Learning from Experience

Background

One of the earliest educators who wrote extensively on the relationship between experience and learning was John Dewey (1938). Dewey believed that the experiences of students in the educational system influenced learning in both positive and negative ways. He advocated progressive education whereby students encountered rich experiences that served as a framework for desirable later experiences. Dewey berated traditional education that provided disconnected, insensitive, callous experiences that resulted in boredom, careless attitudes, bad habits, and inhibited future educational growth. He warned educators that "education and experience cannot be directly equated to each

other" and that some experiences were "Mis-educative ... that had the effect of arresting or distorting the growth of future experiences" (p.25). He wrote that "Everything depends upon the quality of the experience..." (p.27) and "The central problem of an education based on experience is to select the kind of present experiences that live fruitfully and creatively in subsequent experiences" (p.28). Dewey also believed that experiences had continuity and each experience took up where a previous one left off and was learner modified for those that succeeded. Therefore, it became the job of educators to determine where experiences were headed, to shape experiences through the learning environment, to link experiences with the intention of progressive continuity, and to connect education with the social context that learners experienced through living.

Kolb (1984), more recently, advocated learning from experience and felt that the outcomes from this type of learning should be evaluated for receipt of college credit as has occurred in the form of external degree programs. Kolb's experiential learning model linked work, education and personal development and utilized a workplace environment for supplementing formal learning. By integrating experience, perception, cognition, and behavior, learning was viewed as an evolving process, formed and modified as knowledge is applied, derived from, and tested out in experiences. Therefore, "learning is a continuous process grounded in experience" and "one's job as an educator is not only to implant new ideas but also to dispose of or modify old ones" (p.28). Kolb endorsed four abilities in order for learners to be effective: concrete experience, the ability to involve oneself openly and fully in a learning experience; reflective observation, the ability to reflect and observe experiences from many perspectives; abstract conceptualization , the ability to integrate observation into theories; and active

experimentation, the ability to use theories to make decisions and solve problems (p.30).

Jarvis (1992a) described people as the sum of their experiences and believed that all learning incorporated past experiences. Jarvis believed that people experienced life directly through action and reaction, a primary experience, or vicariously through language and communication, a secondary experience. Learning was described as "a response to an experience or even as a response to an experience created through an action" (p. 70). However, as Jarvis (1987) wrote, "Learning and experience are not synonymous, neither are learning and education, but there is considerable overlap between them" (p.17). The author described nine learning responses to experiences within three categories: nonlearning, nonreflective learning, and reflective learning (Jarvis, 1992a).

The nonlearning category was characterized by three responses to experience: presumption, nonconsideration, or rejection. Presumption occurred when people responded to events in an almost thoughtless manner that indicated no desire for change. Most everyday events were handled in this manner as habits are formed and activities are carried out mindlessly. Nonconsideration occurred when people decided not to respond to a situation because of lack of time and/or understanding or fear. Rejection as the term implies occurred when people rejected an opportunity for learning in a given situation. The nonlearning response to experiences has little if any impact on society and the individual; society is unaffected by a lack of response to a situation and the individual is unaffected as knowledge, skill, and attitudes do not change.

Nonreflective learning was characterized by three types of responses to experience: preconscious learning, skills learning, and memorization. Preconscious or incidental learning occurs on the edge of learner awareness or

vision. Comments such as "I was vaguely aware" or "I saw it out of the corner of my eye" are typical of preconscious learning (p.75). Skills learning is a response to the training of such procedures as manual skills or physical fitness. Memorization occurs mostly through communication interaction and results from the repetition of acts. The effects of nonreflective learning on society is one of status quo. Society remains unchanged and individuals learn how to fit in.

The three responses within the category of reflective learning were contemplation, reflective skills learning and experimental learning. Contemplation is defined as "the process of thinking about an experience and reaching a conclusion about it without necessarily referring to the wider social reality" (p. 77). Contemplation can range from meditation to reasoning to the thought processes of everyday life and does not involve action on the part of the learner. Reflective skills learning has been referred to as "thinking on one's feet" (Schön, 1983). By responding to new situations, people use their understanding of events to develop new skills. Experimental learning involves the testing of theory in practice with the outcome being new knowledge. Both reflective and experimental learning involve some form of action on the part of the learner. Whereas nonreflective learning results in conformity, reflective learning contains the two key factors, action and reflection, that are required to learn from an experience rather that just having an experience (Watkins & Marsick, 1992).

Today, experience within the workplace is recognized by many as a legitimate method for obtaining professional knowledge, but not by itself (Smith & Russell, 1991). "Twenty years of experience could be one year repeated twenty times" (p.285). Experience must be active and reflected upon so that it is integrated into cognitive processes as new or expanded knowledge (Jarvis, 1992a; Schön, 1983). Learners will learn best if they are assisted in applying, evaluating, and sometimes redefining theories in relation to practical situations

encountered and encouraged to learn through experience by reflecting on what happened after an event (Smith & Russell, 1991). It is proposed that a preceptorship can be one method for accomplishing this educational challenge and that the writings and research of educators who have studied learning from experience can serve as a framework for this study .

The Meaning of Experience in Nursing

Benner (1984) has completed extensive research on the effect of experience in the development of expertise in nursing practice. Her research is important for this study because preceptors and orienting nurses are at many different levels in terms of professional development. In some settings preceptors with as little as one year of work experience are chosen to precept orienting nurses (Young, Theriault, & Collins, 1989) and orientees can range from new graduates to nurses with many years of experience. The many potential developmental combinations of preceptors and orientees adds to the complexity of the process. Therefore, an understanding of stages of developement particularly as it relates to the implications of teaching and learning is important.

To define and differentiate levels of practice, Benner (1984) interviewed and observed nurses, with varying years of experience either individually or in small groups. Experience was defined as "the refinement of preconceived notions and theory through encounters with many practical situations that add nuances or shades of difference to theory" (p.36). A report of her research, From Novice to Expert (1984), contains clinical exemplars obtained from nurse participants that were descriptively analyzed. Benner's studies have identified five developmental levels of nursing practice: novice, advanced beginner, competent, proficient and expert. Each level is based on skill acquisition (Dreyfus & Dreyfus, 1980) derived from the experience of working as a nurse in a same or similar setting. Characteristics of practice and methods for teaching

were defined for each level and have been used as a basis for understanding nursing practice and for preceptor training. As mentioned, over time, preceptors in any hospital setting orient nurses at all five levels of development and preceptors themselves may belong to any level except novice.

Novice nurses had no experience in the situation in which they must perform. Their practice is rule driven, inflexible, and very limited. In order to practice they must rely on rules provided to them either through their education, institutional policy, procedure, standards, or the word of another practitioner. Nursing students or transfers who enter a situation without any similar past experience are examples of novice nurses. Benner recommended that novice nurses be taught objective attributes of nursing practice, factors that can be measured and have normal and abnormal parameters in addition to the accompanying rules. For example, "the normal range for systolic blood pressure is 100-140 mmHg. However, notify the doctor when the blood pressure falls below 80 mmHg."

Advanced beginner nurses had limited experience and exhibited "marginally acceptable performance" (p.22). The advanced beginner level applied knowledge and skill obtained from their formal learning and brief experience to recognize aspects or global characteristics about patients, such as elements of basic physical assessment. However, observation and assessment elements were viewed as individual "pieces" of information and were not integrated with other facts and only recurrent meaningful situations were recognized. New graduates were generally at the advanced beginner level when assigned to an area where they had some clinical experience as a student. Recommendations for teaching included providing guidelines to identify the characteristics of a situation, followed by practice. In addition, Benner recommended that preceptors provide support and back-up for both the novice

and advanced beginner orientee in order to ensure patient safety in the face of inexperience.

The competent level of nursing was usually achieved with two to three years of experience in a same or similar environment. Competent nurses were able to apply what had been learned from their experience to organize their work, plan ahead and make discriminatory judgments about what factors were important and what could be delayed or ignored. Teaching methods recommended for this level include problem solving patient care situations and simulations and providing opportunities for increased responsibility.

Nurses were able to advance to proficient level with approximately three to five years of experience in similar settings. Proficient nurses perceived situations as a "whole" entity from which conclusions could by formed, rather than as individual unrelated factors. Prior experiences enabled proficient nurses to know what to expect of a situation and therefore to make modifications that may prevent untoward occurrences for patients. This level utilized maxims, descriptors of performance or observations that could only benefit nurses who had enough experience to recognize the significance of the communication. For example, the phrase, "he's circling the drain" to describe a patient that the nurse senses is near death may not have meaning to a beginning nurse, however, an experienced nurse would be able to look at the patient, perceive the severity of the situation, and either agree or disagree. Inductive types of teaching are recommended for the proficient level, such as complex case studies that are discussed and analyzed.

The highest level of skill acquisition, the expert level, was characterized by an intuitive grasp of situations with an ability to "zero in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions" (p.32). Because the expert level had such

deep understanding of a situation, they often had difficulty explaining what their evaluation was based on. Expressions, such as "he (patient) just didn't look good" and "I just knew something was wrong" are common. Benner has suggested that expert nurses may not be the best preceptors for beginning nurses since their practice is so far removed from the rule-governed novice and advanced beginning levels (Urden, 1989). Expert nurses have been found to benefit from discussing and breaking down their paradigm cases and by serving as consultants for other nurses.

Benner's studies (1984) have revealed experience as a requisite for practice development and advancement through levels of skill acquisition. As nurses gain experience in settings where similar situations are experienced time after time, they are able to take pieces of information and put them into context. Eventually, nurses are able to predict what to expect and to move ahead to intervene and prevent potentially serious situations from occurring. Benner supports preceptorships as a mechanism for advancing practical knowledge for both inexperienced and experienced nurses. Preceptors can play an important role in this process by providing meaningful experiences for orienting nurses, explaining the attributes of a situation, and pointing out salient features. Benner's research brings to mind another challenge for preceptors, that of un-learning. Nurses who have developed automatic responses and habits related to their practice may have difficulty adapting to a new environment. Previous experiences affect teaching and learning and un-learning old habits and transposing new habits requires different teaching techniques. Experienced nurses who were comfortable and respected for their expertise in previous employment settings may be very uncomfortable in a new setting and experience feelings of inadequacy and failure and appear headstrong in response to the requirement to change (Cox, 1988).

Other researchers have studied the effect of nursing experience in teaching and learning situations. Pyles and Stern (1983) studied critical care nurses who cared for patients with cardiogenic shock. They found that nurses with experience could go in and "just look at a patient and absorb 15 times as much as another person just by casting an eye over him" (p.53). They labeled experienced nurses who served as mentors to less experienced nurses as "Gray Gorillas" after the "silverback primate who serves as a leader-teacher-protector-role model for his group" (p.55). They observed that nursing units that had Gray Gorilla's were better organized, had a more therapeutic environment, and provided more support for less experienced nurses that resulted in improved job satisfaction. The authors suggested that "concepts of Nursing Gestalt can be taught to critical care nurses through the use of guided experiences with Gray Gorillas" (p.56).

Holden and Klinger (1988) compared the practice of 70 student nurses and 30 experienced nurses in the care of crying infants. The authors developed two computerized situations that involved a teething infant and an infant with insomnia. Subjects were requested to solve the problem, but had to seek out information in order to arrive at the correct cause of the problem. Eventually they arrived at a hypothesis based on the information they had sought. The expert nurses sought pertinent information at an earlier stage in the problem solving process and focused more on the infant than on the information. They suggested the use of computer programs as a means of educating nurses and assessing problem solving skills.

Diers (1981) wrote that nursing involves "a process of thinking that leads from the knowledge to the skills, from the perception to the action, from the investment to the touch, from the observation to the diagnoses" (p.5). How

teaching and learning fit into this process is important to understand yet has not been studied in any depth.

A Model of Learning from Experience

In apprenticeship programs as in preceptor programs, novices work alongside an experienced, competent or expert master. The assumption of apprenticeship programs is that knowledge is "acquired largely by a process of trial and error and that practical wisdom of the experienced professional can be used to reduce the amount of 'on the job' learning and the number of mistakes that the novice must endure to become skilled" (p.98). As a result of the close relationship, skills and knowledge are acquired both consciously and unconsciously, some of which may not even be expressed or known by the expert or master (Polanyi, 1964).

In apprenticeship programs, novices may be passive recipients of the knowledge of their teachers, who transmit the principles of good practice. The disadvantage of this approach is that teachers, who pass on their advice on how to approach problems, can undermine inquiry and reflection of one's practice.

Apprenticeships are classified as traditional and cognitive (Collins, Brown & Newman, 1989). Traditional apprenticeships emphasize the skills required to perform a task within a domain. Lave's studies (1977) have shown that in traditional apprenticeships learning occurs from a combination of observation, coaching, and practice or from the teachers' perspective from modeling, coaching, and fading. The learner observes the expert doing or modeling an accomplishment that results from a combination of subskills. The expert then coaches the learner through the task by incorporating scaffolding consisting of support, reminding, and help when necessary. Through repeated practice the learner becomes more independent in accomplishing the task. The expert gradually withdraws and provides only periodic hints and feedback leading to

increased perfection. Traditional craft apprenticeships are rare today in industrial countries, however, the term is still applied to employees at an entry level who function as trainees (Resnick, 1987).

Cognitive apprenticeships involve teaching processes that experts use to deal with complex tasks or critical thinking and focus on cognitive and meta-cognitive experiences (such as nursing) rather than simply psychomotor skills and tasks (Collins, Brown & Newman, 1989). Knowledge that is conceptual or factual in context is applied to a variety of situations in order to broaden understanding and enrich memory through association. According to Collins, Brown & Newman (1989), cognitive apprenticeships require that experts externalize processes that are normally carried out internally so that learners, under the guidance of an expert, can observe, mimic, and practice them. Based on three success models that have incorporated cognitive apprenticeship for reading, writing, and arithmetic, Collins, Brown & Newman (1989) recommended six teaching methods for apprenticing the acquisition of expert practice: modeling, coaching, scaffolding and fading, articulation, reflection, and exploration.

In modeling, the learner observes an expert carrying out a cognitive function or task so that the learner can build a foundation for accomplishment. In order for this to occur, the expert must externalize the operation by such means as reading, analyzing and/or thinking aloud. Interviews of 450 professional practitioners identified modeling as the most meaningful and helpful form of instruction for high risk situations (Farmer, Buckmaster, and Legrand, 1992).

Coaching consists of experts watching learners carry out a task or operation while "offering hints, scaffolding, feedback, modeling, reminders, and new tasks aimed at bringing their performance closer to expert performance" (Collins, Brown & Newman, 1989, p.481). In coaching, the goal is well

understood between the teacher and learner and the process of reaching an outcome is highly interactive. While coaching is recommended as a technique to be used by nurse preceptors, there is little about coaching in the nursing literature. This may be explained by the origins of coaching in sports and arts, mainly male predominated arenas, while female dominated professions such as nursing are not familar nor comfortable with the practice (Haas, 1992).

"Scaffolding refers to supports the teacher provides to help a learner carry out a task" (p.482). The support can be accomplished by suggestions, assistance, prompts, or physical supports. Scaffolding is a cooperative process where students do what they are able to do and the teacher sees the task or operation to completion by completing aspects beyond the level of ability of the learner. Fading or gradual withdrawal is an integral part of scaffolding. The fourth method, articulation, is the process of having learners talk about "their knowledge, reasoning, or problem-solving processes in a domain" (p.482). Observed methods for accomplishing this include experts questioning learners, having learners talk aloud as they solve problems, and involving learners in critiquing and monitoring a learning situation. Reflection, as described by the authors, is the process of comparing learner problem solving and critical thinking with that of an expert. Last, exploration involves the expert pushing the learner into situations where problem solving and critical thinking will result. In exploration, learners are encouraged to branch out from comfortable situations into more challenging, diverse opportunities.

Farmer, Buckmaster, and LeGrand (1992) reviewed the literature and found no descriptions of cognitive apprenticeships developed for or used by professionals. The authors suggested that cognitive apprenticeships were particularly valuable for dealing with situations that were "ill-defined, complex,

and risky" because the approach teaches "knowledge-in-action" that is "situated" (p. 42). The practice of nursing in the clinical setting fits this description.

Farmer, Buckmaster, and LeGrand (1992) suggest that cognitive apprenticeships occur sequentially in five phases. Phase one consists of behavioral and cognitive modeling of an activity that is essential for the learner to know in order to function within their profession. The activity is modeled in entirety so that the learner can develop a mental image of the real thing. Methods for accomplishing phase one include thinking aloud and teaching the "tricks of the trade." During phase two, learners verbalize their plan and give rationale prior to initiating an action. The master teacher encourages the learner to reflect on the differences between teacher and learner performance. Teaching methods include discussion, alternating between teacher and learner activities, scaffolding, coaching, and remediation as necessary. Phase three is a repetition of Phase Two with teacher fading as learner ability increases. During phase four learners becomes more self directed as they begin to develop their own style and internalize the activity. Teachers provide assistance only upon request. During the final phase, the learner receives advice on how the learned activity can be generalized to other situations. This final phase is important so that learners do not limit themselves only to the learned skill.

In apprenticeship programs, such as preceptor programs, learning occurs in an environment where learners are expected to become productive and safe as quickly as possible. This may be difficult in potentially dangerous situations since professional practice is usually defined by experts. However, in these environments learners are surrounded by others engaged in similar activities with varying levels of expertise who provide them with an opportunity to see the skills they are learning practiced at a higher level and directed to a common goal. This opportunity for observing expert practice, the presence of clear common goals,

and gradual improvement in performance with associated reward are reported to increase motivation and learning (Collins, Brown & Newman , 1989). Therefore, in situations where professionals cannot be safe and survive by using common sense, reasoning, intuition, and general principles, a cognitive apprenticeship that is action oriented may bridge practice and theory and provide an environment safe for consumers (Farmer, Buckmaster, & LeGrand, 1992).

A Focus on Action

Background

Action and reflection have been identified as essential to achieve practical knowledge (Argyris and Schön, 1985; Schön 1983, 1987; Watkins & Marsick, 1992). This recent focus on action and reflection in teaching and learning has mainly resulted from the research of Schön (1983, 1987) and Argyris and Schön (1985). Beginning in the nineteenth century, science and technology rose as the means to save the ills of mankind. Many professions, including nursing, previously developed in the context of service to mankind, were refashioned in a new image of a science based method of preserving health (Schön, 1983). Positivism, empiricism, theory, calculations, and hypotheses became the method of inquiry and the constructs used to explain phenomena (Atkin, 1992). Schön (1983) argues however, that there is a form of professional knowledge that resides in practice. This practical knowledge is constituted and held differently than theoretical knowledge and is dependent upon the experiences that professionals are called upon to manage.

The Nature of Nursing Practice: Science and/or Art

The nature of nursing as science has been widely debated. For many years, scholars debated whether nursing was a basic or applied science, a science or art. Recently, the concept of nursing as a practical science, a combination of science and art, has been explored (Johnson, 1991). Advocates

of the practical science position contend that nursing is not a basic science where the intended outcome of research and learning is knowledge and truth without intention for application; nor an applied science where scientific principles, that serve as a foundation for learning and practice, are decided by other disciplines (Johnson, 1991). Nursing as a practical science combines the concepts and principles of basic science with knowledge acquired and disseminated by other applied disciplines and administers them to the many operations of taking care of patients in a variety of settings. Thus, there are "strong links...between the art of nursing and the science of nursing in that the scientific rules and principles of nursing practice can provide the basis for nursing art" (p.14). Everyday experiences that nurses encounter can only be solved as theoretical knowledge is applied, evaluated based on outcome, redefined, and incorporated into practice (Smith & Russell, 1991).

Schön (1983) relates the dilemma of rigor vs. relevance to topography. Schön refers to the "high ground" as an area where practitioners can effectively apply scientific theory and knowledge to situations that are fixed and straightforward in nature. The "swampy lowland", however, consists of dynamic dilemmas that are not capable of strictly scientific solutions. It is in the lowland that the method of inquiry shifts from research-based theory to "experience, trial and error, intuition, and muddling through" (p. 43). He further relates that if practitioners stay on the high ground they will not serve the interests of society since many issues confronted in the high ground are not of interest to or serve the needs of society at large.

Making Experience Meaningful through Action and Reflection

Within the context of Schön's (1983) viewpoint, knowledge is created through interaction with the environment. This type of personal knowing occurs as practitioners make sense about what they are doing by thinking back on

actions and reflecting. Reflection-in-action involves tacit knowing, that which we know, but do not know that we know (Polanyi, 1964) and the application of knowledge that we have learned (Schön, 1983). Reflection-in-action also relies on repetition. The encountering of situations time and time again is what creates competency and expertise in practice. As practitioners encounter similar situations over time, they learn what to look for, how to respond, and as a result tacit knowledge and the spontaneity of reaction increase (Schön, 1983). As practice becomes routine, however, the experienced practitioner may fail to reflect on practice and may become rigid and heedless of the relationship between practice and the theory behind practice. In this situation, consciousness raising, reflecting on past experiences, affirming the effectiveness of actions through testing, and exposure to non-routine situations are recommended (Watkins & Marsick, 1992). The opportunity for teaching as a preceptor should provide an opportunity for nurses to experience challenging, non-routine situations. Each orientee challenges the preceptor with a different breath of knowledge, prior experience, past life experiences, and learning style. How preceptors meet this challenge will be one focus of this research study.

Figure 1 illustrates what Watkins & Marsick (1992, p.289) believe are the two keys to learning from experience, action and reflection. According to the authors, informal or practical learning from experience occurs only in the presence of both action and reflection. Incidental learning, a subset of informal learning, is unintentional and occurs in the presence of action and absence of reflection. Learning from mistakes and testing limits are examples of incidental learning (Watkins & Marsick, 1992). Formal learning in the presence of reflection and absence of action, and non-learning in the absence of both reflection and action. In relating this theory to nursing, only as knowledge is

applied to practice and reflected upon, will the expertise in caring for patients be developed (Benner, 1984).

	Presence of Reflection	Absence of Reflection
Presence of Action	Informal Learning	Incidental Learning
Absence of Action	Formal Learning	Non-Learning

Figure 1. The Effect of Reflection and Action on Learning.

Schön's model of reflection-in-action has been linked to nursing practice. Powell (1989) studied eight practicing nurses to determine the extent and level of reflection-in-action in everyday work situations. Subjects were observed in practice for two hours and interviewed about their thinking behind observed nursing actions. Data were coded according to Mezirow's (1981) six levels of reflectivity. Findings revealed reflection-in-action of mainly a descriptive, affective, and discriminant nature, with little higher level of reflection on judgment, concepts, and theory. Two community health nurses and one nurse practitioner, whose practices were more autonomous, utilized a higher level of reflective patterns than nurses who practiced in a hospital environment. The author concluded that nurses who rely mainly on theoretical knowledge could become rigid in their practice and not take advantage of practical experiences for learning. Nurses who have a sound knowledge base and are willing to be flexible and work at the practical level with patients in problem solving will develop a higher level of professional development. Planned educational experiences that focused on quality of practice and the practice environment with accompanying rationales were recommended. One example is the preceptor model.

Thus, reflective inquiry is an active process whereby professionals generate their knowledge by examining the means and ends of handling situations (Stevenson, 1993). Rather than learning only technical and scientific

rules, people eventually learn to think like a professional, such as a nurse and to use professional judgment to deal with unfamiliar situations. (Watkins & Marsick, 1992). Attempts to engage learners in this method of obtaining knowledge have involved coaching "students through the process of thinking about problem definition and problem solving as they developed plans for action" (Hart, Naylor, & Sorenson, 1992, p.7).

The Role of Knowledge in Practical Learning

The word knowledge can denote many meanings. Knowledge can mean knowing about something so that one is aware or possesses information, or knowledge can mean familiarity gained through actual experience such as a practical skill (Webster, 1950). Thus there is a knowledge of practice and a knowledge by practice (Elbaz, 1981). How one arrives at knowledge has been referred to as ways of knowing (Baskett, Marsick & Cervero, 1992). Ways of knowing implies that learning is dynamic, that learners are making sense out of experiences which leads to understanding (Belenky et al., 1986). A re-appreciation for ways of knowing in terms of practical knowledge and professional practice has only come about recently, for until the last 20 years, the study of learning has mainly been studied by psychologists within the formal academic arena (Baskett, Marsick & Cervero, 1992; Jarvis 1992b).

The Dimensions of Practical Knowledge

Practical knowledge consists of three elements: knowledge that, knowledge how, and tacit knowledge (Jarvis 1992b). Knowledge that relates to facts, rules, scientific theories, and physiological principles that serve as a basis for sciences (Jarvis, 1992b; Ryle, 1963; Polanyi, 1962). Knowledge how is acquired through doing, observing someone else doing, practice, and experience. Knowledge how may not be able to be explained; for example, a person may be able to ride a bicycle, but be unable to explain how the activity is

accomplished (Polanyi, 1961). Jarvis (1992b) argues that knowledge how would be better stated as "being able to", since in some instances the ability may be present without the knowledge (p.90) and vice versa, a person may "know how", but be "unable to" because of a physical handicap.

Tacit knowledge occurs as knowledge becomes "hidden in the practitioner" (Jarvis 1992b, p.91) and cannot necessarily be expressed in words. (Polanyi, 1967; Boreham, 1992). Tacit knowledge is embedded in an individual's practice and because it has proven to be effective, is relied upon. Change therefore, becomes difficult.

The Impact of Tacit Knowledge on Learning

People come to every learning situation with a background of ideas. These ideas have formed from past experiences and although used for solving and interpreting mental models, many people are unaware of their presence or content (Resnick, 1987x). In formal learning situations, learner's attention is directed away from situation beliefs and ideas and toward more abstract principles (Watkins & Marsick, 1992). However, in informal learning situations formerly learned abilities may be outside the learner's focus of attention. This implicit or tacit knowledge may influence learning either negatively or positively. Habits or automatic responses may not always be good habits and may result in bad practice and resistance to change (Jarvis, 1992b).

Tacit knowledge is acquired by forgetting and learning (Jarvis, 1992b) and by acquiring an intuition that enables individuals to have a Gestalten understanding of an entity (Polanyi, 1964). As practitioners acquire experience they forget ground-rules (Benner, 1984; Ryle, 1963). Over time, approaches to situations and actions are tested, adjusted, sometimes internalized without awareness, and become difficult to explain. Particulars which initially were examined individually, become wholes (Polanyi, 1967) and when encountering

familiar situations, outcome expectations are triggered (Boreham, 1992). Polanyi (1964) contends that knowledge is attained only when one is able to focus away from particulars and see the whole situation. Practices gradually become habits and the abstract concepts of knowledge play less of a role in situations that have been experienced repeatedly.

Tacit knowledge is challenged when situations do not go as expected or when unfamiliar situations are encountered. It is at this point that action and reflection can occur with a resulting increase in practical knowledge that may eventually become tacit (Jarvis, 1992b).

Tacit knowledge has implications for both preceptors and orientees. If experienced, much of a preceptors' practice may be implicit and difficult to explain to a less experienced orientee. Experienced preceptors may not practice by the rules that govern the practice of inexperienced nurses or may break rules, a potential hazard for new nurses. On the other hand, teaching in a way that encourages reflection and action on one's practice may be difficult. Preceptors may not even realize that they accomplish this in their own practice, much less be able to encourage it with others.

Summary

Over the past thirty years, professional education for nurses has moved from hospital settings to academic settings. Universities and community colleges now dominate nursing education as a result of an expanding knowledge base and to control entry standards (Resnick, 1987). This shift in preparation sites has created tension between theoretical and practical knowledge and has challenged hospitals. Preceptor programs, a form of apprenticeship, are espoused to be an effective means for hospitals to bridge the gap between theoretical learning in the academic setting and actual practice in the clinical setting. Teaching and learning that occurs outside the traditional classroom in the workplace is a

complex process and in order to be understood requires a background in the relationship between learning and experience, the components and acquisition of practical knowledge, and the effect of experience on practice. While there is much in the literature about preceptor programs, most authors have focused on describing what preceptors are thought to require, the implementation process, required training, and advantages. How the actual teaching and learning of precepting occurs and how preceptors use the knowledge that guides them in their practice has not been researched and is the focus of this research study.

Benner (1984) has associated experience to the development of skill acquisition and professional development in the practice of nursing. However, having an experience and learning from experience are different and present a challenge to educators in organizational settings (Marsick & Watkins, 1992). One key factor that has been identified to create a learning experience is the process of reflective practice (Schön, 1983). Reflective practice involves having reflective conversations about a situation, framing understanding of the situation based on the experience, trying out actions, and reinterpreting or reframing the situation based on the consequences of action (Marsick & Watkins, 1992, p.9).

Much of the knowledge of nursing is embedded in practice and therefore, experiential learning is essential (Urden, 1989). Practical knowledge, however, is difficult to understand, teach and master and there are few guidelines to assist nurses whose role includes this responsibility. It is purposed that a reflective preceptorship under the direction of an experienced nurse can enhance the learning process, however, how the process evolves needs to be understood in order to be used as a teaching tool for others. "...detailed examination of how people cope with situations of breakdown or transition in their work" are needed to determine how people actually learn and function in the work environment

(Resnick, 1987, p. 18). How preceptors meet this challenge will be one focus of this research study.

CHAPTER III
METHODOLOGY

Introduction

The purpose of this study was to discover and describe aspects of teaching and learning utilized in the practice of precepting. Perspectives were obtained from data collected from both the teacher (preceptor) and learner (orientee). The following questions guided the research:

1. What teaching/learning experiences do orientees identify that assist role transition and socialization to a new work community?

2. What teaching/learning experiences do orientees identify that assist in development of basic knowledge and skills in a new health care environment?

3. What teaching behaviors and activities do preceptors use to facilitate the learning process of nurse orientees?

4. What strategies do preceptors use to reduce the stress associated with role transition of orientation into a new work environment?

5. How do preceptors simultaneously handle their work and teaching responsibilities ?

Overall, this chapter describes the research method used in this study. Following this introduction, the chapter is divided into seven sections: the rationale for selecting a qualitative research method, research design, methods and procedures, record keeping, data analysis, validity and reliability, ethical issues, and summary.

The study is grounded in literature on the practice of precepting, learning from experience, and the theory of teaching/learning and practical knowledge.

The review of the literature demonstrated the need for this study because existent research has not adequately explored the teaching/learning practices involved in the practice of precepting.

Qualitative Research

The Qualitative Method

Qualitative method is an encompassing term that includes broad techniques used to "describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (van Maanen, 1983, p. 9). Qualitative researchers attempt to identify meaningful actions, behaviors, language, problems, and thoughts of individuals, groups, or organizations (van Maanen, 1983) in order to provide a frame of reference and definition of the situation being studied (McClintock, Brannon, & Maynard-Moody, 1983). Van Maanen (1983) identified seven principles for qualitative studies all of which were used in this research study: on-site observation of ongoing social life, observation of people engaged in activities that have meaning, a study of subjects in their natural setting, attention to history as a way of understanding what data represents, attention to perceptions of what subjects intended in terms of actions and meaning, disclosure of "what is going on here", and focus on commonality and shared practices rather than what is different (p. 256).

Qualitative data have been labeled as rich, thick, descriptive, full, earthy, and real. It preserves the flow of time, has face validity, and often discovers unanticipated findings (Miles, 1983). Qualitative research refers to the what, the meaning, and the association, rather than the how and why of quantitative research. (Dabbs, 1982). It is recommended to examine the nature of a phenomenon by looking at "what it does and what effects it has..." (p. 34). Qualitative research was well suited to this study of nurses whose roots are

embedded in humanism and whose practices are much more than just human responses. Such studies of actual practice are required in order to discover the nature and essense of nursing (Leininger, 1985).

The interpretation of qualitative data is largely inductive (Merriam, 1991). While research questions guide the study, the goal of the researcher is to discover new concepts and theories and derive meaningful patterns and categories from data, rather than testing hypotheses.

Rationale for Using a Qualitative Approach

A qualitative approach was appropriate for this study because it facilitated the researcher's attempt to understand and delve into the depths of the practice of precepting within the setting where it occurred (Marshall & Rossman, 1989). The qualitative approach also accommodated the goal of the study, to uncover the lived teaching and leaming experiences of preceptors and orientees and describe them as they occurred in the natural hospital environment. As a result, patterns of teaching and learning emerged within the context of the precepting experience as they actually occurred. In addition, the qualitative approach enabled the researcher to relate the literature that described precepting and learning from experience to the acutal practice and action of precepting.

In this study, it was important that the characteristics and significance of the practical experience of precepting be described by study participants and observed by the researcher. This allowed the researcher to reflect on these descriptions and observations and derive meaning of the phenomenon under study (Parse, Coyne & Smith, 1985). Descriptions of the phenomenon of precepting were analyzed from the points of view of participants in order to derive understanding from the "inside out" rather than from an objective "outside in" viewpoint. Therefore, rather than testing hypotheses, this study attempted to answer questions that provided insight, interpretations, and discoveries (Merriam,

1991) about the process of teaching and learning as it occurred in the world of precepting.

Qualitative research related to the practical knowledge and action of teaching has been encouraged (Atkin, 1992; Brookfield, 1985; LaBoskey, 1994). Narratives about teaching can determine how practical knowledge is acquired and utilized. Through probing and questioning, knowledge can be gained about how the teacher practices and how the learner learns.

In this qualitiative study, the researcher functioned as the primary instrument for gathering data. Two data collection methods were used: observation through photography and in-depth semi-structured interviewing of participants. By using these methods, the researcher was able to obtain a grasp of the data, adapt techniques to the situation, and process, clarify, and summarize data as the study evolved (Guba & Lincoln, 1989). Words and pictures were used by the researcher to intuit, analyze, and describe the world of precepting to construct meaning and understanding rather than testing existing theory as in quantitative analysis (Merriam, 1991; Parse, Coyne & Smith, 1985).

Research Design.

A Case Study Approach

A descriptive case study approach was utilized for this research in order to study precepting in its' natural setting. By using this approach, observation and interviewing of preceptors and orientees led to an understanding of what is meaningful in terms of teaching and learning in an ever changing environment. "A qualitative case study is an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit", in this case the process of precepting (Merriam, 1991, p. xiv). Case studies tell the story of life events and allow the investigator to study a pheonmenon as it is being lived and as it changes over time (Parse, Coyne &

Smith, 1985). Therefore, research questions relate to the "how" and "why" of real-life situations and the investigator has little control over events (Yin, 1984, p. 13). A non-experimental descriptive design is appropriate in this research study, because it is impossible to separate the phenomenon's variables from its context, (Yin, 1984). Case study as a research method is often selected in situations where understanding is desired to improve practice (Merriam, 1991) and to expand and generalize theory where the interventions being studied have no known outcomes (Yin, 1984). In this study, the intervention of precepting, as a teaching/learning approach , was described within the real-life context and the end product is a rich, thick description with interpretation of meaning attached to the data (Lincoln & Guba, 1985).

Case studies may be either single or multiple, determined by whether single or multiple bounded units of analysis exist (Yin, 1984). This research represented a single case study with several homogenous subunits. Although eight preceptors and eight orientees were studied, all data from participants contributed to the bounded system of the study, the process of precepting, a single phenomenon (Merriam, 1991). Several events, participants, and periods of time were studied using a similar approach, (McClintock, Brannon, & Maynard-Moody, 1983) in order to obtain data related to the teaching and learning of precepting. Data from each preceptor and orientee were analyzed separately and compared with experiences of other preceptors and orientees. Conclusions were derived from overall findings that described the case study of precepting (Yin, 1984). The study was longitudinal over an initial four week period of each precepting experience. This period of time was chosen because during the early phase of orientation, intense teaching and learning occur as preceptors and orientees work side by side. This close relationship and interaction enabled the researcher to document the teaching and learning process through photographs

and in-depth interviews. During succeeding weeks of orientation, orientees usually become more and more self-directed and independent and utilize the preceptor more as a consultant and resource, than as a teacher.

Methods and Procedures.

Introduction.

Triangulation involves using multiple sources and methods for data collection and is used to enhance the validity and reliability of qualitative studies (Merriam, 1991). Data in this study included photographs and interviews of eight pairs of preceptors and orientees (n=16). Data were collected from each pair over a four week period of time. Prior to subject selection, permission to photograph subjects and their immediate environment and to interview study participants was obtained from the participating hospital and University of Florida Institutional Review Board (IRB) (Committee for the Protection of Human Subjects).

The Setting

The setting for this study was a 390 bed acute care, Level I, affiliated, tertiary care government hospital with an attached 120 bed Nursing Home Care Unit. The hospital was located in North central Florida. The acute care inpatient area of the study hospital housed three medical nursing units, three surgical units, two intensive care units, two acute psychiatric units, a substance abuse and hemodialysis units, an operating room and a combined medical and geriatric evaluation unit. Outpatient areas include an emergency room, several ambulatory care clinics, and an evaluation clinic. The Nursing Home consisted of two units. Subjects were studied on three medical units and on two intensive care units.

Identifying and Selecting Subjects

Qualitative researchers "willingly sacrifice breadth for depth" (McClintock, Brannon, & Maynard-Moody, 1983, p. 154). While quantitative studies include data related to a few variables for a large number of subjects, qualitative studies seek in-depth data from a few subjects (Patton, 1990). Qualitative researchers strive to study the number of participants needed to provide enough in-depth detail so that those who read the study can understand how an experience is constituted, deepening their understanding of the social processes involved in the experience (Seidman, 1991). In qualitiative research, sample size relates to achieving descriptive redundancy or consensus about the phenomenom being studied (Guba & Lincoln, 1989; Parse, Coyne, & Smith, 1985; Seidman, 1991). When interview data or observations become redundant, data are saturated and further sampling is not necessary.

For this study, subjects consisted of 8 experienced registered nurse preceptors and 8 graduate nurse or registered nurse orientees who were new to an area of practice. Subjects were selected by the investigator from a pool of nurses who were newly employed or who were previously employed in the research setting, but had transferred to a new practice area. The sample was convenient and purposeful with typical cases of experienced preceptors selected by the researcher (Guba & Lincoln, 1989; Patton, 1990; Seidman, 1991). This type of sampling and number of subjects was appropriate for this study because the researcher did not seek data that answered questions of how much or how often, but rather to understand, discover, and gain insight. Therefore, the researcher selected subjects from which the most could be learned and who could facilitate the development and/or expansion of theory (Bogdan & Knopp, 1982; Merriam, 1991; Patton, 1990).

The sample size of 8 preceptors and 8 orientees was selected for this study based on the length and frequency of observations and interviews, the experience of the preceptors, and reports of other qualitative studies (Parse, Coyne & Smith, 1985; van Maanen, 1982, 1983). The 16 subjects provided a sample size large enough to be credible, yet small enough for the researcher to obtain in-depth data within a reasonable time frame (Patton, 1990). The homogenous sample of preceptors was selected by the researcher on the basis of the following criteria: (a) had attended a preceptor development program, (b) had experience in the role of preceptor, (c) enjoyed regard and respect by head nurse and peers as being "a competent, experienced preceptor", (d) were assigned to orient a new graduate or nurse new to an area of practice, and (e) were willing to participate in all aspects of the research project. Preceptors criteria were established to obtain subjects who shared knowledge, practices, and events (Parse, Coyne, and Smith, 1985) related to the practice of precepting. Likewise, the homogenous sample of orientees was selected on the basis of the criteria: (a) were a new nurse graduate or new to an area of practice, (b) were assigned to a preceptor who met the above criteria, and (c) were willing to participate in all aspects of the research project. The criteria for orientees was based on the assumption that "new" nurses required more intensive teaching and because of their inexperience, would be able to place meaning on their learning.

The investigator was notified of newly hired or transferring nurses by the nurse recruiter. Upon notification, the reseacher consulted with the appropriate head nurse to determine the date of arrival and if the preceptor and orientee met selection criteria. If potential subjects met selection criteria, the investigator explained the intent of the study to the head nurse and sought entree to conduct the study on the unit . In all situations, head nurses were agreeable. Following

permission from the head nurse, both preceptors and orientees had the research project thoroughly explained to them by the investigator and upon agreement to participate signed a consent form prior to the study (Appendix A).

Sources of Data

Three primary sources of data were used to describe subjects and discover the teaching and learning aspects of precepting: (a) demographic questionnaire, (b) photographs of the preceptors and orientees, and (c) weekly interviews of the preceptors and orientees. In this chapter section, the methdology for each source of data will be described.

Demographic Data

Questionnaire

Following informed consent, each subject was asked to complete an investigator developed questionnaire that sought information related to age, education, experience, and gender (Appendix B). The purpose of this data was to describe and compare relevant characteristics of subjects.

Demographic description of subjects

The purposive sample consisted of 8 preceptors and 8 orientees. All pairs were followed for four weeks except 1. Subjects 15 and 16 were followed for three weeks because of an illness experienced by the preceptor and subsequent closing of the unit where they were employed due to setting downsizing. Table 1 summarizes the gender, age, education, and experience of the two groups.

Table 1. Demographic Characteristics of Preceptors and Orientees

Variable	Variable Subgroup	Preceptors	Orientees
Gender	Male	0	1
	Female	8	7
Age	Range	37 - 48 yrs.	23 - 54 yrs.
	Average	42.8 yrs.	33.3 yrs.
Basic Nursing Education	Diploma	1	0
	ADN	6	4
	BSN	1	4
Total Experience in Nursing	Range	9.2 - 28.1 yrs	0 - 2.2 yrs.
	Average	17.4 yrs.	0.5 yrs.
Experience in Present Area of Practice	Range	1.5 - 15 yrs.	N/A
	Average	6.4 yrs.	

All preceptors reported having attended a preceptor training program; seven programs were 8 hours in length and 1 was 16 hours. Content of the programs consisted of novice to expert theory (X5), adult learning (X3), teaching/learning (X2), goal setting (X2), and other miscellaneous topics such as problem solving, communication, stress management, reality shock, and hospital routines (X1 each). All preceptors reported previous precepting experiences with a range of 2 to >15 and an average of 7.5. Two preceptors reported precepting one orientee/year, four reported precepting two/year, one reported precepting every four to six months, and one reported precepting < one/year.

Five of the 8 orientees reported having experienced a precepting program previously, 4 as students and 1 as an RN. The lengths of the precepting experiences ranged from 3 weeks to 9 weeks with a mean of 5.66 weeks. One orientee subject reported having two precepting experiences as a student.

Photographic Data

The use of photography in research

As a method of collecting data, the camera serves as an instrument that extends our senses and is able to record observations precisely and in detail (Collier, 1967). Unlike researchers, the camera does not fatigue, has a better memory, and is able to record unlimited detail and subtleties within the range of the lens (Ball & Smith, 1992). When visual images are made, an instantaneous record is captured that becomes a part of the research notebook in the same way that interviews record verbal data (Magilvy et al., 1992). The camera as a research tool captures an instantaneous, lasting image of an event that can be later studied and interpreted in order to communicate and educate about a phenomenon (Hagedorn, 1989). Photographs record the events of an experience and a series of photographs over time can make a strong visual statement about an experience.

The use of photographs as a research tool has been used for many years particularly by sociologists and anthropologists. Margaret Mead was one of the first anthropologists to use photographs as a research tool in recording culture (Mead & Bateson, 1942). In their classical work, The Balinese Character, photographs accompanied and validated Mead and Bateson's observation and field notes. Recently, sociologists have used the camera as a research tool to capture interactions, human movements, group and individual behavior, and interactions between persons and the camera. (Becker, 1981; Ziller, 1990). Phenomenological studies have used still pictures to encourage insight into situations thus enhancing understanding of experiences.

Photography has also been utilized in the health sciences, including nursing, for research purposes. Johnson (1981) illustrated the photographic essays of W. Eugene Smith that defined the practice of study subjects. Smith's

photoessays, The Country Doctor and Nurse-Midwife, consisted of photographic journals where he followed subjects through their daily activities in rural settings. The disappearing practice of rural health care practitioners was captured to such a degree that it stimulated donations to build a clinic for nurse midwives. Higgens and Highley (1986) conducted a study on the maternal role of mothers with first born infants. One component of their research included asking mothers to pose for photographs with their infants in whatever way they felt comfortable. Students and nurse colleagues were able to draw conclusions about the mothering style of the subjects from the photographs that correlated with their research conclusions obtained by more traditional means.

In a study conducted by Magilvy et al. (1992) that focused on home care of elderly clients in a rural setting, photographs were used to record and "map" the environment being studied, capture human activities, orient researchers to the phenomenon being studied, and to encourage dialogue between researchers and study participants. Hagedorn (1989, 1994) combined photographs and interviews to describe the experience of parenting chronically ill children. As parents reviewed photographs depicting their experiences, their memories were prompted and information was revealed that might not have been possible through interviewing without photographs.

Gilliss et al. (1989) included photo galleries in their book that depicted family nursing through case studies. Photographs were used to illustrate child day care, a chronically ill patient, a child and adult with diabetes, and a diabetes teaching center. In their chapter on Child Day Care, 1500 photographs were taken over an eight month period. Panels of experts were shown the images and selected 22 photographs that were most representative of the philosophy of day care. They suggested that photographic nursing research could be used to learn more about ourselves and our work, sharpen visual senses, communicate and

educate, evaluate services, generate new insights and understandings, restructure clinical interactions, and as a stimulus for interviewing. Several of these recommended uses related to this study.

Gerace (1990) used family photographs as a clinical technique with depressed patients. Using the process of photo-interviewing, the author was able to identify themes related to memory and perception and time. The photographs were used to explore the life cycles of patients to facilitate communication and grieving and to raise self esteem. She concluded that photographs should be used as therapy for children, psychiatric patients and geriatric patients.

In addition to recording reality, photographs can also be used to stimulate the process of interviewing (Collier, 1967; Gilliss et al., 1989; Hagedorn, 1989, 1994; Maligvy et al., 1992). Photographs, combined with interviews, enable a researcher to see and listen, a combination that enhances validity and understanding. Photographs record events that may assist study participants to recall occurrences that otherwise would be lost (Hagedorn, 1989, 1994). Photographs have been particularly helpful when repeated interviews are used (Collier, 1967); they bridge the communication gap between researcher and study participant (Hagedom, 1989). Still pictures, when shown to participants, give them something to talk about without much direction from the interviewer, sharpen the memory, and keep the interview focused (Collier, 1967). This study reinforced Collier's findings.

Procedure for photographic observations

In order to record and observe the practice of precepting using the camera and to stimulate the interviewing process, the researcher photographed the preceptor and orientee at least twice during each eight hour shift when both were on duty during their first four weeks of orientation. The researcher would go to

their assigned nursing unit at random times during each day, evening, or night shift, locate the preceptor and orientee and take a picture or series of pictures of each or both, at whatever activity they were engaged in. If the activity involved a patient, the patient was asked by the investigator if he/she would consent to be included in the photograph. If a positive response was obtained, the patient was asked to complete Veterans Affairs Form 10-3203, Consent for Use of Picture and/or Voice (Appendix C). VA Forms 3203 were filed in the researcher's log by date and time. If the activity involved a patient who was not able to grant informed consent, the researcher either took the picture so that the patient could not be identified or left and came back at a later time. If either the preceptor and/or orientee were not on the nursing unit, the researcher either sought them out where they were and photographed them in another location, or if this was not possible, came back at a later time.

In the photographing process, the researcher experienced similar responses from most subjects. During the first few days of data collection, subjects were uncomfortable being photographed and some would pose for the picture or act embarrassed. After a few days, however, subjects basically ignored the process and in some situations were surprised by the flash of the camera as they had not even noticed the researcher's presence. At the end of the four weeks, several of the subjects remarked that they missed the experience of being studied.

Pictures were taken with a 35 mm automatic focusing camera using color film and in most cases included a full body view of study participants with as much range as necessary to capture the activity. Following each photograph or series of photographs, the researcher recorded the date, time, identification of the study participant(s), location, and brief description of the activity.

Exposed film was developed by a local vendor into two 3 X 5 or 4 X 6 color photographs. Photographs were sorted by preceptor and orientee pair and each photograph was labeled with the week and day; for example, week #1, day #4. At the end of each week, one set of photographs for each pair was mounted by the researcher in a scrapbook-like format in chronological order for review during interviews. The other set of photographs was maintained by pair and week at the home of the researcher and used in data analysis.

Description of photographs

The total number of photographs taken for each pair ranged from 40 to 103 with a mean of 69. The disparity in numbers of photographs was accounted for by variations in the number of days actually worked together during the four weeks (due to vacation, education or sick leave), whether the photograph included the preceptor and orientee together or individually, and whether the researcher took one photograph or a series of photographs to record the activity. In some situations, five to six pictures were taken to depict a single teaching/learning activity. Table 2 illustrates the number of total vs. unique photographs taken by subject pair and week. The variation in numbers of photographs between pairs did not effect the research results, since the purpose of the photographs was not a matter of how many, but rather to serve as a pictoral journal for the interview and to visualize teaching and learning activities. The variation in number of pictures can be compared with the varying length of interviews, in some situations there was more to visualize than in other situations.

Table 2. Number of Photographs of Subjects Pairs by Week.

Subject Pair	Week	Total # Pictures Taken	# Unique Activities
1&2	1	12	11
	2	12	11
	3	16	16
	4	13	12
3&4	1	16	12
	2	14	13
	3	18	18
	4	10	10
5&6	1	9	8
	2	8	8
	3	14	14
	4	10	10
7&8	1	17	16
	2	19	17
	3	26	18
	4	23	16
9&10	1	16	12
	2	19	15
	3	18	16
	4	24	16
11&12	1	17	14
	2	21	15
	3	16	16
	4	19	15
13&14	1	22	14
	2	27	19
	3	26	15
	4	29	16
15&16	1	16	12
	2	27	14
	3	21	16

Interview Data

The qualitative interview

Just as people must reflect on their actions to learn from experience, verbal or written reports about experiences can also lead to reflective thinking in order to make sense of them and to promote learning (Seidman, 1991). In-depth interviewing provides a mechansim for researchers to gather data in the subject's own words and then to reflect on the data to gain understanding of actions and behaviors through the perspective of participants. The sharing of experiences by interviewing is the only way for researchers to gain entrance into feelings, desires, thoughts, and meanings that are known only to the person who has lived the experiences (Sandelowski, 1991). Interviewing is also important when the researcher's goal "is to understand the meaning that people involved in education make of their experience" (Seidman, 1991, p. 4). Narratives derived through interviewing describe "lived time" recalled through cognitive and rhetoric processes aimed at "telling about" (Bruner, 1987). Because "telling about" is a cognitive process, it cannot be observed (Pollinghorne, 1988). Only when an event is completed can there be a personal account and explanation; therefore, the interview represents remembrances to be elaborated upon, clarified, and looked back upon (Sandelowski, 1991).

"Qualitative interviews offer the interviewer considerable latitude to pursue a range of topics and offer the subject a chance to shape the content of the interview" (Bogdan & Biklen, 1982, p.136). When the subject is restricted from telling a story in their own words and the researcher controls the interview too rigidly, the interview falls out of the realm of qualitative research. Consistent with the interpretative framework of this study, in-depth, open ended, semi-structured interviews were conducted by the researcher, audiotaped, and later transcribed (Yin, 1984). Structure, in the form of predetermined questions, was avoided until

the end of the interview in order to prevent subjects from unknowingly describing teaching/learning experiences that might be perceived as meeting the expectations of the researcher (Brookfield, 1985). An open ended approach that encouraged subjects to identify teaching/learning activities they had experienced was used to keep subjects focused. Follow up probing was used to elicit more detail about teaching and learning situations that related to different types of activities, such as administering medication vs. caring for the dying patient. The open ended approach included prompting the subject by such statements as, "Tell me more about..." or "What happened when you..." or "Tell me how she taught you that?"

During weekly interviews, subjects were encouraged to reconstruct teaching and learing experiences as close to reality as possible, to unravel the elements of the experiences, and to place meaning on the experiences. When interviewees would gloss over or skip elements of the precepting process, the interviewer would ask for more detail.

Following verbal reactions to the pictures and descriptions of teaching/learning experiences, two final open ended questions were asked of each preceptor during each interview, "Tell me about an experience this week that stands out to you as an example of teaching as a preceptor" and "As preceptor you are assisting your orientee to make a role transition into a new clinical setting. If you were to share something important with another preceptor about how to facilitate the transition, what would it be?" Two similiar questions were also asked of each orientee at the end of each interview, "Tell me about an experience this week that stands out to you as an example of learning as an orientee" and "As an orientee you are making a role transition into a new clinical setting. If you were to share something important with a preceptor about how to facilitate the transition, what would it be?"

The interview procedure

Separate interviews with the preceptor and orientee were conducted at the end of each week of the first four weeks of the preceptorship, except for subjects 15 & 16 who were interviewed for the first three weeks. The weeks were not always chronologically consecutive, since the timeframe may have involved vacation or other leave time for either the preceptor or orientee. The weeks were consecutive in terms of time spent together. Interview appointments were scheduled at the convenience of subjects as close to the end of each week as possible. Because the interviews were conducted during subject's work time, the researcher had to be flexible and sensitive to the demands of workload and scheduling. A total of 62 interviews were conducted in the researcher's office and ranged in length from 25 to 75 minutes. A voice activated tape recorder was used to record data and the researcher took brief notes to prompt follow up questions and comments.

Each interview began with subjects being presented with the chronologically displayed photographs from the preceeding week. The researcher began the session with a statement such as, "These are pictures that show you teaching/learning on the unit during the last week. Please take time to study the pictures and then talk to me about what teaching/learning experiences you experienced last week." Study participants were then provided time to study the photographs. As the interview proceeded, usually participants would go through the pictures one by one in order and talk about what was occurring at the time. Participants were encouraged by the researcher to relate each situation to the process of teaching and learning. Additional interview remarks, probes and questions depended on participants comments and were used to elicit stories about other experiences related to teaching/learning that were considered meaningful from the perspective of the teacher or learner. When interviewing the

orientee, the role and activities of the preceptor and the helpfulness/meaning of the teaching technique were probed. When interviewing the preceptor, specific techniques utilized to promote learning for individual activities were probed, along with the perceived or observed learning outcomes. During the interview, subjects were encouraged to reconstruct details, clarify, elaborate, and reflect on the meaning of their experiences in terms of teaching and learning (Seidman, 1991). The final two questions were asked when participants said they have no more to say about that week. Taped interviews were later transcribed and reviewed by the researcher for accuracy.

As in other research studies (Collier, 1967; Gilliss et al., 1989; Hagedorn, 1989, 1994; Maligvy et al., 1992), the researcher found photographs to be a powerful stimulus for the interview. Not only did they assist subjects in remembering specific experiences, they also stimulated the emotions and feelings that went along with the experience and served as a reminder of another experience that either preceeded or followed the photographed experience. The photographs actually functioned as a series of questions that structured the conversation and took much of the burden of interviewing off the interviewer so that she could listen and observe more attentively. This enabled the interviewer to use observed non-verbal communication as an indicator for further probing or clarification.

Record Keeping

Record keeping is an important aspect of every research project (Merriam, 1991). Demographic information, work schedules of orientees and preceptors, photographs, logs of photographic sessions, and transcibed audio-taped interviews composed the set of qualitiative data used for analysis. A separate file was maintained for each pair of preceptor and orientee, that contained labeled

photographs and audiotapes, transciptions of audio-tapes, copies of informed consent, and demographic data.

Immediately following photographic sessions, the researcher recorded the date, time, location, and events of pictures. Developed pictures were labeled following processing by week and day. The procedure for interview sessions recommended by Merriam (1991) was followed. Therefore, the researcher (a) tape recorded the interview, (b) took brief notes during interviews as reminder to ask follow up questions or elicit elaboration or clarification, and (c) took notes following each interview session to record the date, length, and pertinent comments about the interview.

Data Analysis

In qualitative research, data collection and analysis occur simultaneously (Marshall & Rossman, 1989; Merriam, 1991; Seidman, 1991). During data collection, the researcher gains insight, forms conclusions, and applies ideas and questions from each interview and photographic session to following sessions (Merriam, 1991). Analyses involve reading, reviewing, and reflection on data, reducing data through the process of organization and coding, grouping profiles of individual participants into categories that represent group characteristics from within and between, and connecting pattems to form new or different categories (Seidman, 1991). Within data analysis involves synthesizing data collected through multiple methods for each participant while between data analysis involves synthesizing data for all participants. Connected patterns may contradict or suppport the literature or data from other participants.

Demographic data.

Demographic data were analyzed descriptively to gain insight into the study participants. Demographic data results were related to interview data results in terms of education, life and work experiences, gender, and age.

An Interpretative Approach to Analysis

Interpretive research is appropriate to gain access to the meaning of experience, explore interactions, and understand social processes (Polkinghorne, 1983). Erickson (1986) recommends interpretive research for questions related to education for several reasons: (a) to make everyday life visible and exciting, (b) to understand the details of practice, (c) to consider meanings of the people involved in practice, (d) to compare what happens and what works in different social settings, and (e) to gain understanding that can be projected beyond local settings. Interpretive approaches to analyze data are used when the goal is understanding rather than scientific analysis (Carr & Kemmis, 1986). "The technical method developed for this method of interpreting meanings is called 'hermeneutics' (p.86). Hermeneutics by definition is "the study of methodological principles of interpretation and explanation" (Webster, 1950). Hermeneutics offers a phenomenological approach to the interpretation of literary works (Polkinghorne, 1983). In this study, the narratives and photographs of the practice of precepting constituted the data for hermeneutic analysis. Both photographs and interview data were analyzed using an interpretive approach. Hermeneutics attempts to understand literary works, not from an epistemological scientific way of dissecting or objectifying but rather from an ontological way of entering into the subject's life and situation so that the interpreter can "grasp and be grasped" by the literary work for the purpose of understanding and meaning (Palmer, 1969, p. 26). Hermeneutic principles cannot only be applied to text, but to any form of art that is a work of man (Palmer, 1969; Carr & Kemmis, 1986). By approaching data from a phenomenological perspective, understanding of narratives and photographs become known for what they are rather than by our categories. In other words, findings are revealed through the data rather than hypotheses pointing to the data (Palmer, 1969).

Interpretative Analysis of Interview Data

All audio-taped data were transcribed into a word processing program and placed into computer files to assist with coding and sorting. The process for analysis proceeded as follows:

1) Because of the volume of interview data (n=62), the researcher reduced the data by removing those parts of the interview that did not pertain to the study. Examples included small talk, expressions of speech such as "you know", and conversation that did not pertain to precepting. Each transcript was read several times. During each reading, the researcher recorded comments, questions, and ideas evoked from the data. By reading and re-reading transcripts several times, the researcher became immersed in the data and developed an overall understanding of the meaning of the interview (Marshall & Rossman, 1989).

2) Patterns, themes, and sub-themes were identifed by the researcher through an inductive process of detecting "salient themes, recurring ideas or language, and patterns of belief " that were descriptive of the teaching/learning process (Marshall & Rossman, 1989). This step in the analysis involved questioning, reflecting upon, comparing, judging, and labeling the data until recurring patterns were identified (Marshall & Rossman, 1989; Merriam, 1991). Recurring patterns were compared and combined or set apart until heterogenous categories that could stand by themselves were established.

3) Identified patterns and themes were substantiated by examples from data and by returning to participants to validate interpretations. Each preceptor and orientee participant was sent a copy of the data analysis chapters with a letter asking them to review findings and determine if they agreed with the researcher's findings and to either authenticate, reject , and/or clarify findings.

They were also asked to validate that the interpretation was representative of what had actually occurred. After participants had an opportunity to read the findings, the researcher informally interviewed each paticipant to obtain feedback. In all cases, participants agreed with the interpretation and stated that it accurately described real life.

4) The final and highest level of analysis involves "making inferences and developing theory" (Merriam, 1991, p. 140). This step involved a mental process that attached meaning and understanding to data that could be inferred to future situations. Findings were substantiated by existing literature or stated as new theory that could be applied to the phenomenon being studied.

Analysis of Photographic Data

Photographs were analyzed as a means of elaborating on and validating interview data. Photographs were initially arranged chronologically to facilitate participant interviews. Following interviews, photographs were grouped into descriptive categories such as person(s) in photograph, activity, location of activity, physical relationship between preceptor and orientee, etc. Photographs were reviewed several times by the researcher and representative photographs were selected to authenticate and visualize patterns and themes that emerged from interview data. Finally, selected still pictures were combined with findings from interview and demographic data to produce an overall interpretation of the practice of precepting and the teaching/learning process which occurred in the precepting process.

Validity and Reliability

In qualitative research where understanding is the goal, concerns for validity and relaibility are different from studies that strive to test hypotheses. Validity and reliability should be of concern to investigators throughout the research study including developing research questions, data collection, analysis,

and interpretation (Merriam, 1991). The goal of interpretive researchers becomes one of establishing scientific rigor and trust (Hall & Stevens, 1991; Lincoln & Guba, 1985; Merriam, 1991). In qualitiative studies, the terms internal and external validity and reliability and are replaced by the terms truth value, transferability, and consistency (Hall & Stevens, 1991; Lincoln & Guba, 1985; Marshall & Rossman, 1989).

Achieving Internal Validity or Truth Value

Internal validity or truth value is concerned with whether the research findings represent the phenomonon being studied as they are and as they are working (Lincoln & Guba, 1985; Merriam, 1991). In this study the researcher jointly constructed the world of precepting as viewed from the perspective of both the teacher and learner. Therefore, internal judgments of truth were derived from those who were studied and who were close to the situation (Merriam, 1991). Three strategies were used to enhance truth value: participant validation of interpretations, peer review, and triangulation (Hall & Stevens, 1991; Merriam, 1991). In regard to participant validation of interpretations, both preceptors and orientees were asked to validate findings "to determine whether they recognized, understood, and endorsed the researchers' interpretations of their experiences" (p. 22). In regard to peer examination, findings with substantiating data were critically reviewed by two nurse researchers who were familar with and had conducted interpretive research and two educators who had conducted multiple qualitative research projects. Triangulation, the third technique, involves "using multiple investigators, multiple sources of data, or multiple methods to confirm the emerging findings" (Merriam, 1991, p. 169). In this study, data sources included both preceptors and orientees from eight separate and distinct preceptor experiences. Data collection sources included both photographs and interviews.

Achieving External Validity or Transferability

External validity or transferability refers to the extent to which findings from one study can be generalized or transfered to other situations (Merriam, 1991). In qualitative case studies the goal is to understand the investigated phenomenon in depth in the natural setting. Therefore, generalizing findings has little meaning since the phenomenon will never be the same in another time and place (Lincoln & Guba, 1985; Merriam, 1991). The benefits of qualitative research are founded on the value of meaning and understanding of experiences that can be compared, differentiated, and transferred to other situations. Findings can be generalized to theoretical propositions, but not to populations (Yin, 1984) and application to other situations is left up to the discretion of the reader and other investigators (Erickson, 1986). This study attempted to improve transferability by collecting rich, descriptive photographic and interview data from both preceptors and orientees and by comparing preceptor experiences with each other to formulate characteristics that make up typical effective teaching methods (Merriam, 1991).

Achieving Reliability or Consistency

Reliability generally refers to the extent to which research findings can be repeated and produce the same results (Merriam, 1991). Since naturalistic studies will never produce the same results, dependability or consistency of results becomes important (Lincoln & Guba, 1985). Consistency is achieved when there is a fit between the collected data and the phenomenon being studied. Strategies employed in this study to enhance consistency included a thorough review of the literature in order to explain assumptions and theories that were related to the study, triangulation as described earlier, and a detailed description of the methodology and data analysis process so that other

researchers would be able to duplicate a similar study (Marshall & Rossman, 1989; Merriam, 1991).

Ethical Issues

Each researcher is responsible for producing and conducting a study that upholds ethical standards (Merriam, 1991). This responsibility begins with an awareness of the feasibility and ethical issues connected with the study (Marshall & Rossman, 1989). The investigator of this study adhered to requirements of the study site and Investigational Review Board. In addition, the investigator adhered to ethical standards by protecting the identity of participants and study site, safeguarding data, presenting data so that it could not be linked to individual participants, being sensitive to the time donated by preceptors and orientees, acquiring permission to use photographs, and telling the truth in reporting findings (Marshall & Rossman, 1989; Merriam, 1991). In addition, the researcher was vigilant to the sensitive environment in which the study took place. When taking photographs, if the activity in which the orientee and/or preceptor were involved invaded the privacy of the patient, the researcher would leave and come back at a future time.

Summary

In summary, this research study was conducted using a qualitative method to describe the practice of precepting. Four semi-structured, in-depth interviews were conducted with seven preceptors and seven orientees (n=14) during the first four weeks of the orientation period and three interviews of one preceptor and one orientee (n=2) during the first three weeks. In addition, two photographic sessions were conducted every day during the four week period of orientation in order to observe events and to act as a stimulus for interviews. Interviews and observations were supplemented with demographic data related to education and experience. Data were analyzed using an interpretative

approach with findings taken back to subjects for verification to enhance validity and reliability.

CHAPTER IV
A PROFILE OF STUDY PARTICIPANTS, THE SETTING, AND AN INTRODUCTION TO STUDY FINDINGS

The purpose of this study was to discover an awareness of the practice of precepting or orienting new nurses in a hospital setting. Data were obtained from 8 preceptors and 8 orientees through a series of 4 weekly interviews and still pictures taken daily. A total of 62 interviews were conducted and 555 pictures taken between May and September 1994.

Teaching and learning practices embedded in precepting were explored holistically through a single case study design. The sample of preceptors and orientees was chosen based on pre-established criteria. For preceptors the criteria included (a) attendance at a preceptor development program, (b) experience in the role of preceptor, (c) a high regard and respect by head nurse and peers as being "a competent, experienced preceptor", (d) previous assignment to orient a new graduate or nurse new to an area of practice, and (e) a willingness to participate in the research project. Criteria for orientees included (a) being a new nurse graduate or new to an area of practice, (b) being assigned to a preceptor who met the above criteria, and (c) a willingness to participate in the research project. The theoretical framework for this qualitative study was established by reviewing literature on the practice of precepting, learning by experience, and informal learning in the workplace.

The following research questions guided data collection in this study:

1. What teaching/learning experiences do orientees identify that assist role transition and socialization to a new work community?

2. What teaching/learning experiences do orientees identify that assist in development of basic knowledge and skills in a new health care environment?

3. What teaching behaviors and activities do preceptors use to facilitate the learning process of nurse orientees?

4. What strategies do preceptors use to reduce the stress associated with role transition of orientation into a new work environment?

5. How do preceptors handle their work and teaching responsibilities simultaneously?

Study Participants

The 16 study participants, consisting of 8 preceptors and 8 orientees, were purposively selected by the researcher. The researcher validated that each preceptor and orientee pair met study criteria through conversations with the nurse recruiter, appropriate head nurses, and subjects. Because of the time involved in interviewing and picture taking, no more than three pairs were followed at one time. All subjects approached by the researcher were willing to participate in the study.

Profile of Preceptor Participants

The 8 preceptor participants were females who ranged in age from 37 to 48 years (average = 42.8). Six preceptors were graduates of two-year associate degree nursing programs, one graduated from a three-year diploma program and one from a Baccalaureate nursing program. Years of experience in nursing for study preceptors ranged from 9.2 to 28.1 years (average = 17.4). Experienced preceptors who had graduated several years ago questioned whether their dated formal nursing education affected their ability to teach new nurses, particularly new graduates. These feelings were illustrated by reflective comments made by two preceptors, the first with 10 years experience and the second with 20.

> Mostly sometimes I wonder if I'm capable of teaching new people. Sometimes I feel kind of burned out and I'm not sure if I'm doing it on right track or if I'm doing the right thing. There's moments I have my doubts. Everytime I do it again, I wonder if I'm missing something. Since I've been out of school so long there's probably a lot of things that have come up since then.
>
> I think I might do better with precepting people that are not GNs [graduate nurses]. This is the first GN that I've had. I think I do better with people that have some experience....It's hard for me to remember, and all the stuff that they don't know, you forget. They don't know a lot of the basic stuff, even basic judgment things...

These comments related to Benner's (1984) concern of whether experienced nurses are the best preceptors for new graduates or nurses with little experience. The concerns are based on the differences in observed practice patterns. Inexperienced nurses are rule governed and need guidelines to direct their practice, whereas, experienced nurses are guided by intuition gained through work experiences. The concerns of preceptors, however, were not realized by orientees in this study.

As required by study criteria, all preceptors indicated they had attended preceptor training ranging in length from 8 (n = 7) to 16 (n = 1) hours. Training had occurred as recent as 9 months prior to the study and as distant as 1988. Those who had attended more recent training were able to recollect topics included in the training more vividly. All preceptors except two indicated that some teaching/learning topic had been included in their training. These included adult learning, teaching/learning, and establishing goals and expectations.

Preceptor participants indicated prior experience in precepting, ranging from 2 experiences to more than 15 with a frequency of one per year to 2-3 per year. Their regard and respect as preceptors was validated by head nurses and peers through informal conversations with the researcher. Remarks validating their practice included, "She's the best preceptor I know", "I've had good

feedback from the orientees she's precepted", and "They can't get any better than her."

The preceptors had both positive and negative memories of when they were both orientees and preceptors. Remembrances of these experiences served as a framework for their practice. The guidance that these past experiences provided is illustrated by the following comments made by two preceptors who recollected prior orientation experiences.

> In this hospital, I had been in the [name of hospital], and what was confusing to me, my preceptor was on vacation. I went through four different nurses. It was like they assumed I knew everything. Things weren't explained to me. Then going through four different people, then my regular preceptor did come back, and she in the matter of one day clarified everything. Never assume that a person knows things.

> She [orientee] also took me back to when I was the orientee. I remember so many negative things. I've tried not to treat my orientees the way I was treated. My first day is an experience I'll never forget. I was seventeen when I entered nursing school and it was a diploma school. I never had been in a hospital. The first semester was all classes. The second semester we go to hospitals. I went to a cancer hospital. My first patient had a tracheostomy. It was for me a very traumatic experience. Then the patient wanted to talk and I couldn't understand him. It was very frustrating for me and no one was there to help me.

Past negative experiences served as lessons of learning for preceptors and were incorporated into teaching directed at avoiding similar experiences for orientees. As one preceptor related, "I try to pick out things that may have gone bad for me and if someone would have knowingly directed me around it or told me that yes this will happen but hold on, you'll get through this."

Likewise, past positive experiences, whether as a learner or teacher, were modeled and repeated in the practice of preceptor. Comments such as, "I remember when I was orienting, it helped me a great deal...", "I know for me, that's how I learned", and "this is something I do routinely with all orientees....I've gotten positive feedback" were incorporated into examples of teaching/learning situations. Thus preceptors were connected to and reflected on their past

experiences, good and bad, and incorporated them as actions in the practice of teaching orientees.

Preceptors began their association with orientees understanding that, "I am responsible for everything she [the orientee] does during this period." This responsibility was "kind of scary. If my name is going to be behind everything they do, to me, that's really scary." Preceptors felt, "Unsure, I always feel unsure...not knowing if I'm going to be able to give the person what they need." Along with concerns of being able to carry out the responsibility of orienting the new nurse were feelings of, "She is very exciting for me...I think she's going to be an excellent nurse." The meaning and strength of the interactive relationship that formed between preceptors and orientees was expressed by one preceptor, "My favorite people are the people I've precepted in the unit. It's kind of like, I hate for them to get off orientation. I'm friends with them forever." Thus, preceptors entered into their relationship with orientees with the weight of role responsibility, the excitement shared with the new nurse orienting to a new job, and realization of the potential for a long term relationship that may result if things went well.

Profile of Orientee Participants

The 8 study orientees consisted of 7 females and 1 male ranging in age from 23-54 years (average = 33.3). Three orientees were new graduates of associate degree in nursing programs, three were new graduates of baccalaureate programs, and two were nurses with 2.1 and 2.2 years of experience beyond graduation and had transferred to new practice areas. One of the transferred nurses had an associate degree and 1 a baccalaureate degree in nursing.

Five orientee participants had been involved in previous precepting experiences, 4 as students during their final semester practicum and 1 as a new

graduate in a different practice area. Previous experiences were depicted as both positive, negative, or a combination. One orientee related:

> I had one [preceptor] that just didn't like me .... And she kept saying things like, "Wait a minute that's not what happened at all"... I just was on such edge, and it just increased my anxiety level to the point that I was doing all the patient care ..., but I wasn't getting anything. You know, I would look at the charts and everything and go, Huh? because my anxiety level was way up there. And she went on vacation,... so I was assigned this other woman. [name of woman], she walks on water. She knows, she should be a doctor, she knows everything, she's amazing, I mean, as a human being. She is just an amazing creature. And it was the most wonderful experience. I learned so much .... Boy, the person that you're assigned to can, whew! ... I'll always be grateful to her.

Orientees entered into their new jobs and preceptorships with a divergence of feelings and expectations. For new graduate subjects, the feelings reflected their transition from student to nurse and ranged from "It's exciting" and "It doesn't seem real ... I'm a nurse" to, "I was panicked, of course. I had this over-rising feeling that I didn't learn enough in nursing school. I should know a lot more than this before I get turned loose on a poor helpless patient." The new graduate subjects realized the dimension of their status change as they reflected their new role and responsibility in relation to "I don't have the experience and the knowledge yet. I hope they don't expect me to have everything." One subject expressed her feelings as follows:

> It's just an uneasy feeling and I don't know, I feel a lot different than I did when I was here for my practicum. Because when I was here then, I didn't have the responsibility that I do now, you know, I'm out of school and I'm responsible for these patients. And it's just real scary to me now because I've seen some instances .... I couldn't function by myself in many situations and that's a scary feeling, that if I couldn't do something or I'd just die. You know, you have this fear you're going to kill somebody, you know. And that's a scary feeling and I don't want to be put in that situation.

Transition responses expressed by orientees who had some nursing experience were no less apprehensive. Different equipment caused "confusion" and new types of patients led to "I get frustrated basically, I don't know what's

going on. That bothers me." Changing work environments also diminished the level of skill acquisition as one orientee shared, "After coming from a place where I knew exactly what I was doing almost at all times, to coming downstairs and wondering if I'm going to cut it down there." In fact, the experienced orientees considered themselves at a disadvantage because:

> Yeah, when you're a new graduate, you don't have any bad habits and you're not used to working somewhere and you're not used to a routine. It's a different set of guidelines down here [newly assigned unit]. A different world. It's a different type of stress...

The phrases verbalized by orientees to express feelings about entering into a new work environment included, "I was panicked", "I'm just kind of stressed", "I was pretty nervous", and "Overwhelmed and frustrated." These types of feelings impact the ability of orientees to learn and illustrate the need for an environment that supports the learning process and protects both the orientee and patient from the lack of practical knowledge and experience (Boud, Keogh & Walker, 1985).

Throughout the interviewing, orientees described feelings of being different from more experienced nurses and vulnerable. The feelings were arrived at as they made comparisons between themselves, their preceptors and other more experienced nurses. In addition to not knowing the environment and not knowing how to do the expected work, orientees related they were not able to get the same amount of work done, didn't know how to respond to many situations, and didn't always see the same picture as their preceptor.

In relation to work, an orientee summarized the difference between she and her preceptor by recognizing, " she didn't walk nearly as fast as I do and she gets twice as much done." Orientees recognized that they did not organize their work in the same way as their preceptors and reported,

> Well, I was going into a room and not having what I need and then go back out and sign it out and go back in and chasing up and down from one

room to another and...they call me and say, this patient has to go there and go back ...

Although orientees recognized the role that experience contributed to practice, at this point in their new job, they marveled about how much information their preceptors knew about their patients and other patients in the unit. As one orientee explained, "I don't know how they [experienced nurses] give that much information between each other, because I have enough problems just giving enough information on my own patient." In relation to charting and reporting, an orientee related that with the preceptor "all this information pours forth", but for herself, "I don't remember little details that happened and things that were done and things that changed, and things that looked different. Orientees also reported that "she remembered something I didn't remember or she noticed something that I didn't notice" and "I don't know what to be calm about and what not to be calm about ..." While the orientees, just like all humans, were alone with their feelings and with the experience of being new, they were not alone in terms of being understood, supported, and guided as will be shown in the following three chapters.

Study Setting

Knowledge about the study setting is important in order to visualize the research environment, understand the impact of the setting on aspects of teaching and learning, and if desired, to replicate the study. In this study the types of patients cared for affected the setting and standard practices and, therefore, the required knowledge and skills, assignment of patients, where nurses spent their time, and how preceptors attended to their orientees.

As stated in Chapter III, the setting for this study was a 390 bed acute care, university-affiliated, tertiary care government hospital with an attached 120 bed Nursing Home Care Unit. The hospital is located in North Central Florida.

Within this setting, study participants were purposively selected from two distinct areas, acute medical units (n = 4 preceptors & 4 orientees) and intensive care units (n = 4 preceptors & 4 orientees). The distribution of participants was unintentional and occurred as a matter of chance. While data related to teaching and learning and the role of the preceptor were similar across both inpatient settings, there were differences in the size of units, acuity levels of patients, and patient care delivery systems that influenced how patient care assignments were made and what factors were emphasized during the orientation period.

The Medical Unit Setting

Four orientee and 4 preceptor study participants were employed on 3 acute inpatient medical units, 2 with 30 beds and 1 with 40 beds. Patients were located in private, semi private and five bed ward rooms. A central nurses station served as a location for patient charts, computers, and telephones. On these units, nurses delivered care to patients using a primary nursing model. The total patient population was divided into groups in geographic proximity with each group containing six patients. A primary nurse was assigned to each group and was responsible and accountable for the total care of that group of patients. Total care included bathing, feeding, administering medications, educating the patient and family, discharge planning, and communicating with other members of the health care team about patients' needs. In addition, the nurse responded to any patient situation that may arise on an unexpected basis, such as chest pain, changes in vital signs, unanticipated behavior, or family needs in response to the patient's illness. Nurses also responded to the constant influx of orders or decisions that came from doctors and the health care team. Pictures taken of nurses on medical units showed that nurses spent much of their time in the nurses station transcribing doctors orders, reporting to other nurses, documenting in the patient's chart, and in hallways preparing medications,

obtaining supplies, and traveling from area to area (Figure 2). The remainder of time was spent with patients and families.

Figure 2. Preceptor and Orientee Preparing Medications in Hallway on a Medical Unit.

The four preceptor subjects selected from medical units were primary nurses with responsibility for their own group of patients and sometimes for another group in the absence of a primary nurse. Two preceptors also functioned as charge nurses for the units. Charge nurses functioned as assistants to head nurses and were responsible for administrative aspects of the unit. The primary nursing model provided continuity and repetition for the orientee during the learning period and required the preceptor to balance the complexities of the many roles of preceptor, primary nurse, and charge nurse. As one preceptor commented:

> I'm not only charge nurse, but I also have a primary group. That helped in my role with her [orientee], because in the past when I was precepting, I didn't have a primary group and it probably was harder for an orientee to follow me...Having a primary group, I was able to pinpoint the things you do for individual patients.

When a preceptor received an assignment that included her own primary group and another group, she would, "primarily let her [orientee] manage our primary group, the same ones she'd been used to and I oversaw the other." During the first two weeks of the preceptorship, the preceptor and orientee "worked on a group of patients together." "Her patient was my patient" and "the way she [preceptor] started out was, okay, go ahead and follow me around." By the end of the third week, the orientee's assignment became more autonomous as described by an orientee, "She has pretty much tumed me loose with the team [primary group] of patients and 'just hunt her down when you need her' sort of thing." During the fourth week, "We [orientee and preceptor] are still together some of the time. I had my own patients yesterday, and if I needed her I could call her to help me."

The Intensive Care Unit Setting

Four preceptor and 4 orientee study participants were selected from 2 intensive care units (ICU), 1 medical with 10 beds and 1 surgical with 12 beds. The ICUs were designed so that patients are visible from most locations. In these units, the preceptor and orientee pair were assigned patients by a charge nurse with the preceptors "getting in a word" to indicate which patients they preferred for themselves and their orientees. The number of patients assigned to each pair depended on the acuity and number of patients and the number of staff on duty. Typical assignments were usually one or two patients per pair and sometimes three. The assigned nurse was totally responsible for patient care as previously described on the medical units. The ICU patients differed from medical patients in their acuity level and reliance on technological devices such as monitors, ventilators, and pacemakers. Patients also received a variety of intravenous medications that were titrated up and down by the nurse, based on precise measurements and calculated hemodynamic information. The ICU

environment is one where patient crises are constantly anticipated. As a result, pictures showed that ICU nurses spent the majority of their time at patients' bedsides administering medications and measuring and monitoring changes in their status (Figure 3).

Figure 3. Preceptor and Orientee Documenting at Patient Bedside in an ICU.

In the ICUs, patient assignments were allocated to the preceptor by a charge nurse and with "input from the orientee", the division of responsibility was decided. In the early phase of orientation, "a patient that is stable enough, but someone that [orientee] can also learn from" was preferred. An orientee reported, " ... She doesn't want to give me anything too complicated, yet. She wants me to get simple patients and really take care of them and go from there." A combination of providing continuity and learning new things were factors in assignments that allowed the orientee to see the spectrum of illness, to develop organization skills, and to experience new situations and find solutions to problems. As one preceptor commented,

> I try to let [orientee] stay with the same patient two or three days so that [orientee] has some continuity and sees the progress in the patient. On this patient, we had him for three days in a row. [Orientee] had a chance to see when he got better, then he got bad, and then needed a Swan Ganz.

The continuity of assignment was appreciated by orientees and viewed as an enhancement for learning. Caring for a different patient every shift with unique needs and responses created an ongoing process of relearning roles and responsibilities. Being assigned the same patient for several days enabled the orientee to, "be familiar with who I [orientee] was going to take care of" and provided a repetitive learning situation that would promote the reinforcement and expansion of skills. As one orientee related,

> So far I've been able to keep the same patient and see that the first day wasn't wasted because the second day went so much better using what I had learned the first day.

As the orientation progressed, the preceptor would, "try to pick [types of] patients that we have not had yet, patients that are a little sicker." This process might involve "moving out of cardiac and into respiratory", "picking up two patients and coordinating the care for both of them" or "taking a lung today, that will be a little different."

Unlike medical units, patients and, therefore, orientees caring for patients were visible from most areas in the ICUs. Visibility of orientees affected their assignments and as an orientee reported, "she's got me taking my own patient" at the end of the first week. Assigning a patient to an orientee at an earlier stage than on the medical units was possible because the preceptor was able to observe the patient and orientee and to know the needs of fewer patients. Such an assignment was reported by a preceptor on a busy night shift with an assigned responsibility for three patients, "I gave her the two stabliest patients in the unit that were right next to my guy so I could watch hers. I'd also had those two guys so I know them well."

Participant and Setting Summary

In summary, the 8 female adult preceptor subjects were experienced nurses who were respected and well-regarded by peers and supervisors as teachers of orientees. They represented a total of 139 years (mean = 17 years, 4 months) of nursing experience, demonstrating familiarity with the content area they chose to teach. They were knowledgeable of the teaching setting, as evidenced by a mean of 6 years, 4 months experience in the training area. Preceptor participants had received minimal training in the practice of precepting and, therefore, relied not only on their training, but also on past personal experiences, as an orientee and preceptor, to guide their practice. These experiences had provided preceptors with a sense of how it felt to be precepted and directed not only what to do, but what not to do.

Preceptors entered into their roles understanding their responsibilities and wondering if they would be able to provide orientees with what they needed. The preceptors had graduated from their academic nursing programs many years previous. Length of time and changes within the field or nursing since their formal learning were a concern to them.

The 7 female and 1 male orientees were adult learners with an average age of 33.3 years. Six orientees were recent graduates and 2 had transferred to new areas of practice. The majority of orientees had been in preceptor programs previously and entered into their new jobs with memories of both positive and negative experiences. The orientees were excited about their new jobs and concurrently anxious about their new role and responsibility.

The research setting consisted of two diverse areas, medical inpatient units and intensive care units. These two areas represented different nursing care delivery systems and physical layouts. This affected the types of patients

cared for, the required knowledge and skill of staff, and the assignment of patients.

Introduction to the Study Findings

Although participants had various education and experience backgrounds and preceptors had little training in teaching and learning, preceptors shared several practices related to (a) teaching/learning basic skills, (b) teaching/learning about ill-defined, complex, and risky situations, (c) teaching/learning organization, (d) teaching/learning about salience as a basis for establishing priorities, (e) interpreting the picture, (f) transitioning orientees into a new work environment, (g) safeguarding the patient and orientee, (h) balancing the dual role of preceptor and patient caregiver, (i) launching the orientee, and (j) the journey to independence: advice from beginning to end. The methodology of using interviews and still pictures for this study was advantageous in identifying patterns and themes and providing the researcher with verbal and visual data which depicted both the teacher and learner sides of the story. During interviews, preceptor teachers provided descriptions of how they conducted their practice, and orientee learners substantiated the practices and validated the meaning of behaviors and actions. The open-ended interviews with orientees provided insight into feelings related to role transition, whereas, interviews with preceptors revealed how they recognized and affected those feelings. In most interviews of a preceptor and orientee pair, similar teaching/learning stories were told, similar feelings and needs were expressed and recognized, and both understood the same struggles associated with developing a new way of thinking and doing. Thus, interview data obtained from one person in the pair validated data obtained later from the other and vice versa.

Pictures further defined and authenticated patterns and themes. During interviews, pictures helped to focus preceptor and orientee pairs on the same

situations so that teaching and learning viewpoints could emerge. Pictures brought forth feelings associated with specific situations causing participants to recall and relive them. Interpretation of the relationship between the preceptor and orientee was expanded and enriched by being able to visually capture non-verbal communication. Pictures revealed both what preceptors and orientees did together and apart as well as the roles that each played in teaching/learning to care for patients. Specifically, pictures added a visual dimension to the interview data that enabled the researcher to connect body language with description, to visualize how preceptors and orientees sited themselves during described teaching and learning situations, and, overall, to see and hear the practice of precepting.

Chapters V, VI and VII will describe the ten patterns and associated themes discovered by analyzing interview data and authenticated by pictures. Patterns and themes will be expressed from the viewpoint of both the teacher (preceptor) and learner (orientee). Photographs will be used to represent what has been put into words as well as what can be seen but was not put into words during interviews.

CHAPTER V
THE TEACHING DOMAINS OF PRECEPTING

Five domains that constitute the teaching practices of preceptors will be described in this chapter: (a) teaching/learning basic skills, (b) teaching/learning about ill-defined, complex, and risky situations (Farmer, Buckmaster, & LeGrand, 1992), (c) teaching/learning about organization, (d) teaching/learning about salience as a basis for establishing priorities, and (e) interpreting the picture. The five domains were embedded in interview data that described a comprehensive picture of the practice of precepting and constitute a major segment of that practice. The described domains accounted for the lived experiences of preceptors and orientees as they taught and learned about nursing. The domains represent how teachers constructed their practices and are helpful in understanding what a preceptor is and does and how an orientee comes to acquire practical knowledge and skill in a new clinical setting. These practices, often taken for granted, disclose how precepting is situated within the practical context of an organizational setting. The strength of these findings results from their being embedded in the practice of preceptors and were validated by participant teachers and learners.

The teaching domains will be described as a linear chain of events. However, in reality, teaching was a dynamic, responsive, and holistic process as preceptors fluctuated back and forth among different teaching practices, adjusting to each situation. Therefore, the teaching practices were pieces of a process that would eventually fit together into an integrated whole rather than occur as a linear chain of events that followed a set pattern.

The Teaching/Learning of Basic Skills

Nurses practice in the dynamic environment of hospitals in which an underlying routine is often entwined with unexpected occurrences. The dynamic nature of the setting dictates the knowledge and skillful actions necessary for staff to function safely and effectively. It is within this setting that preceptors teach and orientees learn the practical knowledge and skills of nursing practice.

While academic institutions attempt to equip students with the theoretical knowledge and beginning skills required for professional practice, a gap exists between what nurses who are new to a setting know and what they are required to know in order to practice safely and effectively. The challenge for preceptors is to recognize what knowledge and skills orientees bring to the work situation, to help integrate theory and practical knowledge, and to teach what orientees have not yet learned.

One of the most repetitive, consistent teaching challenges preceptors described was teaching orientees basic skills required for patient care that had not yet been learned or mastered. These basic skills were integral to patient care and although the types of skills were different on individual study units, descriptions of how teaching occurred were consistent. Teaching these skills occurred throughout the four weeks of interviews. Some skills were part of the daily routine care of patients and were able to be repeated frequently. Other skills were situational as required by individual patient needs and were performed as opportunity arose. Skills were considered basic if they required a one time explanation/demonstration, could be repeated with minimal assistance, and required little repetition and follow up. Examples of basic skills included learning to work with equipment such as intravenous pumps and performing procedures, such as suctioning. Knowing basic skills was important for orientees in order for them to comfortably manage the daily routine of patient care.

Teaching by Talking

Teaching basic skills was primarily done by talking and occurred for the most part at the bedsides of patients (Figure 4). "Talk is of the highest elemental importance in [learner] development at all but perhaps the highest levels" (Daloz, 1986, p. 226). Talking serves many purposes including enabling learners to hear different perspectives, to encourage, to inform, and to question. Teaching by talking was not idle conversation but focused on information aimed at giving a purpose for, understanding of, and meaning to the task. Talk was essential to the practice of precepting and was described by a preceptor as follows, "During the orientation process I talk all the time and when I go home my husband says, 'Why won't you talk to me?' and I just say, 'I've been talking all day and I can't talk any more."

Figure 4. Teaching by Talking at the Bedside: ICU.

Teaching by talking was depicted in separate interviews with a preceptor and orientee pair as they described teaching/learning about a basic skill, measuring cardiac output.

> Preceptor: The first time, I explained the procedure...and then I did the first one. Then we ran a set of three. I ran the first one. I asked him to do the second and the third. Then I guided him through the process...The second time he did it by himself. He did good.
>
> Orientee: The first time we did it together. I was doing the mechanics of it, and she was telling me what to do. The second time ... I tried to do as much of it as I could myself, and then when I got stuck she'd tell me what to do, and the third time I just did it by myself.

Teaching basic skills was described as a four phase process: preparing the orientee for doing, guiding the orientee through the skill the first time, filling in the learning gaps on repeated performances, and providing feedback. Teaching by talking served as the foundation for the four phases of the learning experience. Talking occurred in advance of the basic skill and continued through all phases of teaching. Each of the four phases was characterized by a different type of dialogue serving a different purpose and are described below.

Phase one: Preparing the orientee for doing

In the first phase of the teaching, talking was carried out mainly by the preceptor and included the what, how, why, and when associated with each specific task. Pre-skill conversations with orientees included, "I told her what to look for", "I told her how we were going to do it", "I detailed all the equipment we needed ... and told her what our role would be", "I explained to her about the patient", and "I talked to her about the importance of ..." According to orientees, preceptors transmitted information, "just in depth enough to where if I [orientee] hear it enough, I'll be able to add it to my learning." It was apparent from interview data that preceptors explained "step by step" what orientees needed to know and do and "made it clear ... what went where and what meant what." In some instances during the first phase, preceptors combined telling with showing;

they demonstrated, while "talking through" the skill. As one preceptor described, "I showed her first, talked through it, and then when we had the opportunity, she was able to go ahead and do it on her own." The combination of showing and telling provided the orientee with action and words as preparation for doing.

Phase two: Guiding the orientee through the basic skill

The second phase of the process was guiding the orientee as they performed the skill the first time. In comfortable situations and without prior demonstration, the preceptor would "walk her (orientee) through it, with her doing it as opposed to my doing it ... and let her go ahead and do it step by step." A preceptor described walking through as, "I'm verbally at her side." During the "walking through" the preceptor was guiding the sequence of events by telling the orientee what, when, and how to do the skill. During a first time suctioning procedure, the preceptor guided the orientee in, "what equipment to get", "when it was time to put the tube in", and "how to get around the esophagus and down the trachea." The outcome of the talking/walking through in terms of learning was described by an orientee as "I knew exactly what to expect...The next time...I'll remember that experience step by step ... something like that is a perfect learning experience, so you'll remember exactly what to do."

The decision of whether to let the orientee do the procedure with explanation but without prior demonstration was based on a combination of factors including the receptiveness of the patient to be a part of a learning situation, available time, prior knowledge/experience of the orientee, and safety for the patient. Whether the orientee did the task with or without prior demonstration, orientees found the walking through technique helpful. As one orientee explained,

> That helps me a lot. It's [sic] actually hands on and if it's being explained as I do it, I seem to be able to put it together more than if somebody were

> to tell me, or if I were to just watch. If I'm involved with it, my brain clicks in better.

The individualized teaching with the preceptor at the orientee's side focused the orientees' perception on what they needed to know, ensured a safe environment for the patient, enabled orientees to learn and reflect on learning by doing, and gave them experience in the environment where they would be using the skill. In combination, these factors enhanced the learning experience.

Phase three: Filling in the learning gaps

The third phase in the process of teaching basic skills consisted of filling in the gaps during repeated performances. Again, this phase was mainly accomplished through talking. As orientees repeated the performance of basic skills, preceptors would "be there next to (orientee)" to "remind", "review", assist with what they were "unsure of", and "check and double check." The degree of preceptor input required during this phase determined when orientees would perform the skill independently. Preceptors had a sense of when this independence should happen and deemed orientees as "checked off" when they were able to perform the skill correctly and when "she felt comfortable doing it", "she didn't need reminding", and "she didn't ask any more questions." Orientees also had a sense of their own readiness to perform skills independently. As one orientee explained, "I think she (preceptor) was away, she was doing something and it was time for me to take another cardiac output, so I just did it myself. " This self directed behavior on the part of the orientees demonstrated their awareness of readiness to act independently and assume responsibility for the learned skill. It also demonstrated that orientees, as adult learners, were not totally dependent on preceptors to make decisions about when competence in an area had been attained.

Phase four: Providing feedback

The final phase in the process was providing feedback; feedback of how the orientee had done and feedback related to the relationship of the achievement to their future. Feedback is illustrated by a preceptor's response to an orientee's accomplishment.

> I [preceptor] went over and patted her on the shoulder and said, "See now, that wasn't so hard." And she [orientee] said, "No, no, I feel really good." I said, "Good, cause you're going to do the next one." And she said, "Okay." And she got this little grin on her face and she did the next one without any problem and I think that is a big step to really accepting the challenge of [doing] an admission.

Having observed the orientee successfully perform a basic skill, the preceptor congratulated her on her success and represented the accomplishment as a step in learning rather than a single attainment. The orientee responded to the feedback with a sense of accomplishment and acceptance of the challenge for further learning. This exchange demonstrated the importance of the relationship between the preceptor and orientee. The feedback provided by the preceptor was perceived as an honest vote of confidence for the orientee that indicated it was safe to move forward in the learning process.

Preceptor feedback also provided orientees with an experienced critique of situations and heightened their awareness of what they might have done differently. This level of feedback was provided to an orientee who shifted her attention away from an unstable patient to talk to a family member and did not immediately see a change in blood pressure. The preceptor said,

> You [the orientee] were doing what you needed to be doing, talking to the wife. The only difference was you weren't facing your patient. When your patients are really unstable, you want to keep one eye and one ear open. If the wife wants to be there, shift it around a little bit, because they [patients] change fast.

The preceptor promoted learning by prompting the orientee to reflect on how she could simultaneously pay attention to the patient and family. The feedback gave

the orientee the message, you did all right, but ... The preceptor endorsed the orientee's action of dealing with the family but told her that, based on her experience, that was not enough with this patient.

Both of these examples demonstrated how feedback was used to send a message which would promote learning. The first example helped the orientee realize that the accomplishment was a step toward more advanced learning, while the second example highlighted achievement and raised consciousness of what could/should be done.

Summary of Teaching Basic Skills

In summary, teaching basic skills consisted of four phases, each grounded in teaching by talking and occurred in most instances at the bedside of patients. During the first phase, preparing the orientee to do, dialogue focused on the what, how, why, and when of the skill. The purpose of the dialogue was to establish a cognitive basis for the action being learned. During the second phase, preceptors verbally "walked" orientees through an action, providing step by step guidance. The guidance enabled a hands-on experience that had purpose and meaning for the work setting. During the third phase, preceptors filled in learning gaps by retelling and/or reminding that which was not remembered during the first two phases. The fourth phase of feedback provided orientees with verbal messages to make them aware of what was yet to come and/or that which should/could be changed to improve practice.

Teaching about Ill-Defined, Complex, and Risky Situations

Throughout the four weeks of data collection, preceptors taught orientees how to manage situations that were ill-defined, complex, and risky in nature. Situations were considered ill-defined, complex or risky if they required repeated explanation and modeling, were learned and practiced over time, had to be followed with prolonged observation and coaching, and/or involved managing an

unpredictable or unstable patient care situation. Examples of ill-defined, complex, or risky situations were administrating medications, documenting patients care and progress, communicating with peers and doctors about the patient's condition, and dealing with unexpected patient situations, such as chest pain.

These situations occurred in almost every normal working day and their occurrence was unpredictable. Anticipating the required knowledge and skills was difficult because of the uniqueness of each situation. Because the knowledge and skill needed to manage the situations could only be learned by doing at the bedside of patients, close supervision was essential.

Learning about ill-defined, complex, and risky situations by doing required not only knowing how to manage the situation, but also understanding the situation. Understanding included anticipating the consequences of what could happen by doing or not doing. Confronting complex situations that are spontaneous and immediate requires reflection-in-action (van Maanen, 1991). Reflection-in-action is the internal process of judging whether one is acting appropriately in a situation. The reflection occurs while the situation is ongoing and differs from reflection-on-action which occurs following a situation. By reflecting-in-action situations are dealt with and worked through in the best way possible.

Each complex situation or activity consisted of a number of details that were knowledge and skill-based and resulted in a comprehensive act. Devoloping skills to manage these situations required an understanding of details specific to each individual situation. An example is teaching about administering medications. The focal and practical act of giving a patient a pill or injection needed to be backed by subsidiary knowledge of the medication, including action, normal dosage, and side effects, knowledge of equipment used, and

knowledge of the procedure for administration so that the right medication would be given to the right patient in the right manner. For most of the complex activities, preceptors were adding to what was learned during formal education and previous experiences. Bringing forth the known and supplementing it with the unknown enabled orientees to skillfully apply knowledge and work successfully in their new environment. To accomplish this, preceptors utilized a number of practices to teach ill-defined, complex, and risky activities to orientees. Practices utilized by preceptors included teaching by example, teaching cognitive rules, switching places, and debriefing.

Teaching by Example

One practice used in the process of teaching ill-defined, complex, and risky situations was teaching by example (Figure 5). Teaching by example is used to teach activities which cannot be detailed and for which there is no prescription (Polanyi, 1958).

Figure 5. Teaching by Example: Administering Medication on a Medical Unit

Learning by example involves mutual trust to the degree that the learner watches, emulates, and follows the example of the teacher. To gain that trust, teachers must know a skill well enough so that they can demonstrate it and earn the respect of the learner.

Preceptors explained teaching by example as, "I did not have her do any kind of medications or anything. I just had her following and observing and encouraged her to ask questions" and "showing her how I did it and taking her through the steps and letting her observe some of my charting."

Learning by example was described by an orientee as she explained the purpose of making bedside patient rounds with her preceptor at the beginning of the shift.

> I've gone on morning rounds with her [the preceptor] every morning and it's been neat watching the way she interacts with the patients. It's been neat to realize what it means, it's primary nursing on that floor. It helped me realize...that she knows those patients and that she's had those same patients and there's a rapport, they talk back and forth easily and she understands them. They know what to expect from her and that's valuable. That was really neat to watch.

Without putting anything into words, the example of the preceptor enabled the orientee to gain an understanding of the purpose of morning rounds. The understanding led to a realization that the level of interchange between nurse and patient was possible because of the relationship that had developed between the preceptor and her primary patients. The orientee realized that making morning rounds was not a simple act of stopping by each patient's bed to say good morning, but rather a complex act of connecting with the patient, sharing plans for the day, and assessing the patient's condition. By viewing the activity as enacted by the preceptor, the orientee learned the value of knowing and connecting with the same patients over time. By reflecting on the preceptors' example the orientee became aware that morning rounds consisted of interactions between nurses and patients that were grounded in relationships

developed from knowing and connecting with each other. Participating in the activity alongside the preceptor eliminated the need to talk about intricate processes that were implicit, implicit in the sense that the preceptor may have been unaware of precisely what she was doing and could not put it into words (Boreham, 1992). Thus by example, the orientee came to know the value of connecting with patients as a part of nursing practice.

Preceptors often combined teaching by example with talking. Teaching by example combined with talking aloud was an extension of the talking described in teaching basic skills. The talking described in teaching basic skills was talking aimed at instructing orientees how to do a task. The effectiveness of the blending was described by an orientee.

> Best way [of learning] is her doing and just follow her. And seeing her doing. She doesn't just do it and I watch, she explains what she's doing. This is what I need to do, this is what I'm doing now.

Preceptors described the practice as "talking out loud." As preceptors were working in a situation, they would be articulating what they were doing and thinking. Expressing what they were thinking as they were doing enabled orientees to hear thinking so they could gain a sense of how preceptors made decisions about patients. Orientees also had an opportunity to learn to care for patients by seeing and hearing preceptors taking care of patients. The blending of doing and talking also allowed preceptors to care for patients and teach at the same time. The combination of doing and talking was important in this study because, in most instances, preceptors themselves had patient care assignments and did not have the opportunity to stand back and teach. Talking combined with teaching by example was reflective dialogue aimed at sharing thinking. By talking about their thinking in combination with example, preceptors were able to combine thoughts with actions.

In the early phases of teaching complex activities, preceptors facilitated learning by making it possible for orientees to learn through observations, particularly when a situation was tense or time was limited. Preceptors understood that if orientees felt responsible for a situation without the necessary knowledge and were uncomfortable, they would not learn. Therefore, preceptors would do whatever was necessary to allow orientees to be observers in situations they were not yet prepared to handle. An example of such a situation was explained by a preceptor who described taking care of a patient with chest pain.

> This man had ... developed chest pain when he came back from his PTCA. It was not being relieved. She [the orientee] was titrating up the nitro and we got morphine administered. Because of his anxiety, she also gave him some Ativan. She hadn't pushed many medications before, so that was new to her ... Because his chest pain was still unrelieved, we started him on Breviblock. She was pretty much overwhelmed. I had the doctor push these [medications] because I could tell she was overwhelmed. I showed her how I was going to do it with the Breviblock. I showed her how we were monitoring it. A couple of days later we had another patient who was to be started on Breviblock and she did it all.

The preceptor realized the orientee was overwhelmed in the situation, yet she wanted to teach her how to administer the medication, Breviblock. To facilitate learning in this tense situation, the preceptor directed the doctor to administer drugs rather than the orientee or herself. Removing the orientee from the pressure of the situation so she could focus on learning and allowed the preceptor the opportunity to teach about the medication. This description also exemplifies a learning environment where other people contribute to the learning of a colleague by doing what is necessary to teach by example.

Teaching Cognitive Rules

Another practice preceptors used to teach complex activities was teaching or facilitating the acquisition of cognitive rules specific to situations (Figure 6). In some settings rules for activities may be optional and learned through trial and error. However, in the hospital setting, maintaining safety for patients is

fundamental, and therefore, teaching rules for inexperienced nurses is essential. Rules created a bounded safety zone in which the orientee could practice. Boundaries indicated to the inexperienced nurse when to seek assistance. Until experience could be gained, rules for activities provided a sense of structure upon which new nurses could build their practice and test the boundaries from experience to experience.

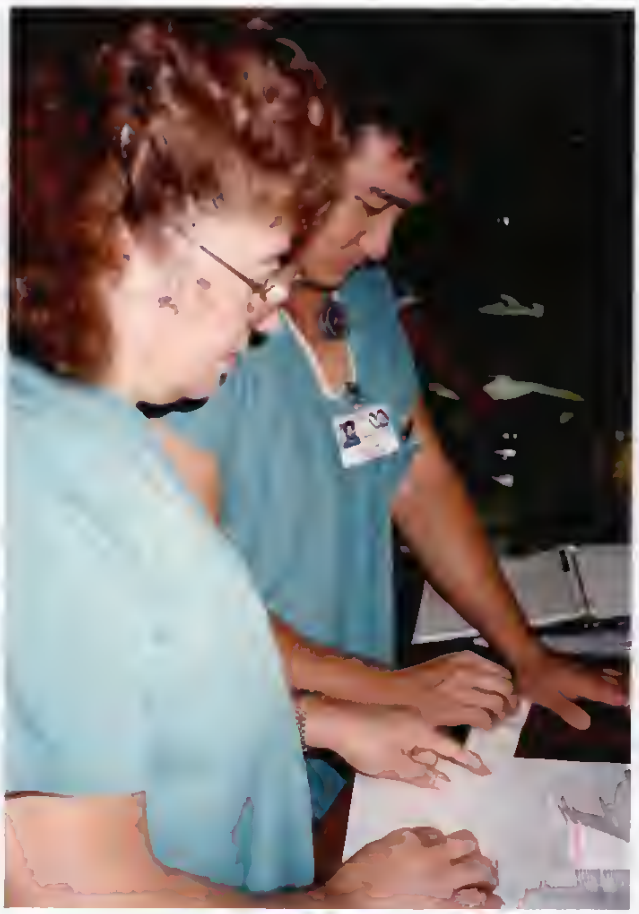

Figure 6. Teaching Cognitive Rules about Arrhythmia Interpretation in an ICU.

While it is not known from this study whether preceptors were taught about the importance of teaching cognitive rules for orientees, several preceptor participants reported learning about novice to expert theory in their preceptor training (Benner, 1984). Benner emphasizes that the behavior of beginning

nurses is rule-governed and is based on formal models and theories learned in education programs. By following the rules, new nurses are able to practice safely in situations for which they have no experience.

Cognitive rules take many forms including practical rules learned through experience, written rules established by organizations or the profession, and theoretical rules obtained through formal education and literature. In instances where rules were not known and were not accessible through written materials, they were articulated by preceptors as representative of their thinking and experience. In other instances preceptors directed orientees to written materials that contained rules or pieces of rules. Articulated rules provided the how, what, and when for situations, such as when to titrate medications up and down, what cardiac rhythms could be watched and which required prompt intervention, and "what was important in a [progress] note and what things don't need to be in a note." The explanations were not intended to be memorized as facts, but rather to provide insight into the situation. In some instances rules were lessons preceptors had learned from personal experience as described,

> When the doctor comes out we need to ask him, does he want us to call him with the chest pain, before a nitro, ... I told her, you have to really attack these guys [doctors] sometimes because otherwise you'll never know what's really on their minds ... Some patients just have chest pain and they say, "Oh fine give them three nitro," but you need to know ... they don't write everything that they're thinking.

Cognitive rules were imparted as preceptors talked during teaching by example. Preceptors also may have directed orientees to resources such as other members of the health care team, books or articles. These variations were illustrated by preceptors in the following three examples.

> Interviewer: How do you teach her [the orientee] how to teach a patient?
>
> Preceptor: I let her observe me. After I've done the patient teaching we go someplace and I tell her this is what I told him and this is why I told him that. Then explain to her the different steps and why I gave him the

> information that I did. With going through as a student she had to do some of the things also, so it's familiar information to her, but it's different now that she's responsible for it
>
> I discuss the parameters once they're set. I said, when he goes outside this parameter you need to notify [the doctor]. If there are any rhythm changes, you have to notify. If it's a rhythm change, I would notify the doctor myself. I don't want a delayed call. Sometimes you have to go see. Sometimes the reading is false. The monitor isn't that intelligent.
>
> What I tried for a change of pace was having her [the orientee] make a list of the questions that she had, including some drugs that she was unsure about and told her, take an hour and a half and take your books and I had brought in some other resource material that I had and gave her at least an hour or two opportunity to look up some of these things and then we were going to plan to meet at a later date to share what she had learned and kind of go over the material.

The above data illustrated how rules for situations were provided by preceptors based on their knowledge and experience or encouraged though self-directed inquiry. The relevant and situation specific information facilitated the transfer of previously learned knowledge to practice and supplemented what orientees did not know but needed to know to practice safely. Rules were imparted to and/or interpreted for orientees at a level that had meaning at the point they were in the learning process. An orientee told about learning rules for vasoactive drugs.

> If it's nitro, she [the preceptor] tells .... I guess the basics. If it's nitro, she tells me watch his blood pressure. Don't let it drop too quickly too much. With nipride it's, I guess blood pressure, but you know, she's told me that it's got a short half life and that after you cut the drip, thirty seconds later you're going to see his blood pressure come back up. With the Dopamine, when it's a renal drip, she tells me just watch his output. Make sure it's coming real well. When it comes time to start titrating them, she tells me to watch it for thirty minutes and if it's stable, then cut it down. I mean, I guess she has her own guidelines, but she says, if you have any questions, don't listen to me, go to the book. Because the book will tell you exactly .... I've probably asked about three or four different nurses what they do for certain drugs and every one of them will give you a different answer, but every one of them will also add, "Go look at the book, if you have any questions about it. Because that's your most reliable source."

The above example illustrated the judgment and timing the preceptor used in deciding what type and how much information to impart at the point in time of learning. The experienced preceptor knew when and how to titrate drugs but she recognized the need for the new nurse to learn the rules early in her practice. Without learning the rules, new nurses will not safely learn how to manage variations in managing clinical situations. The preceptor encouraged the orientee to think for herself and seek information from other sources. The preceptor provided rules in a manner that kept the patient safe, yet encouraged the orientee to think reflectively and transfer the guidelines into their experience so that they had meaning for them. As described by another orientee, "I wasn't familiar with the drug, so I went and looked it up and realized ... one of the parameters we were worried about wouldn't be affected at all ... From now on, I will know the action for that drug." The orientee realized that knowledge learned and incorporated into practice took on a different meaning than knowledge that was known but not applied. The application of *knowledge that* (theoretical knowledge) to *knowledge how* (practical knowledge) resulted in an applied practical knowing that could be tried and tested through experience (Jarvis, 1992a). Only when language has situation-specific meaning will learning have occurred.

During the process of teaching rules, preceptors involved orientees as active learners rather than passive recipients of information (Knowles, 1978). Encouraging them to seek information from other resources has been described. In other situations, preceptors would challenge orientees to question and explain. As an orientee explained,

> She [the preceptor] showed me how to do the nursing care plan...And we talked back and forth. She said certain care plans they use. I picked one and she asked why I had picked it and I explained. If I missed anything she explained why the care plan was necessary. Lots of conversation.

In the described learning situation, the preceptor shared her opinion and asked for the learner's opinion. The exchange of information enhanced understanding between the teacher and learner and during the exchange, the preceptor determined whether rules were understood. Thus, the preceptor received feedback about how her teaching was transferred into learning by the orientee.

Switching Places

Another practice utilized in the process of preparing orientees to handle ill-defined, complex, and risky situations was switching places (Figure 7). In prior practices, preceptors functioned in the many aspects of the teacher role. In this phase, preceptors became assistants to orientees in order to facilitate their taking on responsibility for situations.

Figure 7. Switching Places While Doing a Dressing on a Medical Unit.

Switching places occurred during the third and fourth weeks of data collection and served two purposes. Preceptors were in the immediate environment of orientees so they could observe and evaluate their level of

learning and ensure safety for patients and orientees. At the same time they could assist with basic tasks, thereby freeing orientees to handle more complex responsibilities.

During this phase, preceptors referred to themselves as "techs" and "assistants" and described the role as follows,

> I'm establishing my role as a tech ... like a silent teacher and I help her with planning and things like that, but basically I'll do the more tedious things like dumping urine, taking vital signs, drawing blood because these are basics that she's already mastered and she is very aware that they need to be done...

During this period independence was encouraged and preceptors would say, "call me when you're ready" or would "watch at the foot of the bed and not next to" the orientee. Preceptors would encourage orientees to "tell me what to do," would "step in and take over" only when asked or if they observed that the orientee was overwhelmed. Preceptors also challenged orientees to reflect upon and explain what they were doing and why. Encouraging reflection was accomplished by having orientees come to them "with their plan of care and running it by them," by asking a lot of questions "because it's my way of seeing what she's thinking," and by sitting down "every couple of hours to review what's going on." These conversations enabled orientees to obtain feedback on whether their plans or actions were appropriate to the situation and to make sense out of what they were doing during the process of relating them to preceptors.

Switching places was facilitated by having the same patient assignment over time as explained by an orientee.

> We had him [the patient] three nights in a row. The first night this was all new to me ... I did a lot of watching and I did the little tasks I could do. I was her tech for the first part ... I was kind of acting on her orders and she explained why we were doing and what were doing as we went along ... The next couple of nights, I took him. She was my tech. I had gone home

and read about certain things. She was right there and I could ask all the questions I wanted.

During this phase, while preceptors were "in the periphery," they were "keeping an eye on ... the patient's response as well as interaction with the family" and "making sure she's not going down for the third time, but allowing her to be her own nurse and plan her day." As explained by a preceptor, "I watch her a lot. Even when I'm across the room." Switching places allowed preceptors to stand back and reflect on the practice of orientees. Their watchfulness and listening provided an opportunity to deliberate about where the orientee was in the learning process and decide on the best course of action for the future.

Debriefing

The final practice used to teach orientees to handle ill-defined, complex, and risky situations was debriefing. Debriefing involved conversation between the orientee and preceptor that took place after a situation or at the beginning or end of a shift. Debriefing sessions created an opportunity for reflection on a situation and included what had occurred, accounted for actions, and discussed how practice could be structured or altered as a result of the experience (Pearson & Smith, 1985). Debriefing occurred following situations where the orientee and preceptor were so intensely involved or things happened so quickly that they did not have time to think about and reflect on what had happened during the experience. Debriefing also occurred as a planned event to review experiences that happened during a shift. A spontaneous debriefing session was described by an orientee and preceptor following a situation where a patient's condition had deteriorated without warning and required prompt emergency action. The situation occurred during the first week and the pace and activity within the situation became so demanding that the preceptor "came in and took over" and the orientee "stepped back because she had never been there."

> Orientee: And then after the situation was over and the patient was stabilized, [the preceptor] and I took some time to talk about what had happened. Things that happened prior to this event and then we reviewed the kind of things that I would need to do in case this happened again. Like if I saw these EKG changes, I would immediately get a 12 lead EKG and get these medications at the bedside waiting in case the doctor wanted them. That was a really good way to learn because until you see someone in that situation, it's kind of hard to be in it.
>
> Preceptor: We did a critical analysis of what had happened and I asked her, well, tell me the process that you saw with me being the nurse and you watching me that you remember so that next time if it happened you'd be one step ahead. And she was able to identify the fact that I ordered an EKG right away for cardiac changes. I requested that cardizem be at the bedside and by that time the physician had been contacted twice. She saw that I had gone and knew the location of the intubation equipment, so those are the things that I think that although she may not have actively been in participating in, at that point in time that she would remember, had she been alone she would be able to facilitate that herself. So I was very careful to make sure that she felt what she did was great. And that she was doing well and that it was a normal process for her to go ahead and step back at that point and that she would feel in her process that she would want to step forward next time...

The debriefing session provided an opportunity for the preceptor and orientee to step back and reflect on a fast paced multi-faceted experience and relate happenings to role and responsibility. Both the teacher and learner engaged in a critical analysis of the situation in order to create meaning and understanding of the events that occurred. The preceptor was able to review and explain her actions so that both could come to conclusions about their effectiveness.

The described experiences illustrated the three stages of debriefing: discussing what happened, discussing how the involved people felt, and discussing the meaning of the experience (Pearson & Smith, 1985) in this situation from the perspective of an experienced and inexperienced nurse. By discussing what happened, both had the opportunity to hear and compare their experience and discover a common starting point for discussion. In terms of feelings, the preceptor was sensitive to the orientee's level of development and

emphasized that her reaction to the situation was normal for her stage of learning. However, to facilitate learning, the preceptor made the orientee aware of what actions she had performed that enabled her to handle the situation. This provided practice guidelines that the orientee could use to guide her in similar future situations. Without debriefing, the orientee would have had an opportunity to watch and listen to the situation but not to discuss and reflect and have her understanding brought forth, enhanced, and validated by the preceptor.

Other interview data described debriefing that occurred at the beginning or end of a shift. While these debriefings were not exclusively for the purpose of discussing ill-defined, complex, and risky situations these types of situations were an integral part of discussions. An orientee described the impact of the strategy on her learning.

> Orientee: Then at the end of the day, we'll kind of summarize the whole day as far as the way it looked after the shift as opposed to the way it looked at the beginning, including priorities, changes in conditions, new medications. We're constantly going back and referring back to things we said earlier.
>
> Interviewer: Is that a positive thing for you.
>
> Orientee: It helps a lot for me because I'm able to put things together more, looking at the whole condition as opposed to one aspect. [The preceptor] brings it all together.

In these situations, the focus of discussion was on "things that have happened during the day." The communication promoted an increased awareness of the effectiveness of actions and ideas of "if there were ways we could have gotten things done a little bit easier." In addition, preceptors used the sessions to obtain feedback related to their teaching. Preceptors asked questions such as, "Did you feel overwhelmed, or did I go too fast ...?" Thus the sessions provided two-way understanding of how the orientee had performed as a learner and how the preceptor had performed as a teacher.

Summary of Teaching about Ill-Defined, Complex, and Risky Situations

In summary, preceptors taught orientees how to handle ill-defined, complex, and risky situations by utilizing four practices: teaching by example, providing cognitive rules, switching places; and debriefing. In teaching by example, preceptors modeled and orientees observed the practice of preceptors in situations that were difficult to explain and break down into details. By reflecting on their observations, orientees were able to understand how aspects of practice were accomplished. Teaching by example sometimes occurred in combination with talking out loud. Showing and talking out loud enabled preceptors to keep up with their daily patient care responsibilities and teach the orientee.

Providing cognitive rules involved supplying orientees with boundaries in which they could practice safely. Initially the boundaries were taught by preceptors or learned through self directed inquiry from other resources. Over time cognitive rules were tested and adapted by orientees from situation to situation.

Once the knowledge and skill of the orientee had been observed to be relatively safe, the preceptors facilitated and monitored practice by switching places with the orientee. The orientees became the primary caregiver and the preceptors became assistants to the orientees who responded to their requests and needs. This sometimes tacit practice enabled preceptors to begin distancing themselves from the learner, yet assured safety for the patient and prolonged their role as a resource and supporter.

The final approach was debriefing. Debriefing sessions occurred following spontaneous, fast paced situations where the level of involvement precluded teaching. Therefore, following the incident, the orientee and preceptor would review and reflect on what happened, what feelings were involved, and what the

meaning was in terms of practice. Debriefing also occurred at the beginning and end of shifts to review the day happenings to understand what had occurred or decide how things could have been done better.

Teaching about Organization

Another domain that preceptors described was teaching orientees how to organize their work. Organizing work is an area that is talked about in nursing schools, but acquisition of organizational skills requires delegation of responsibility and experience with the complexities of assignments. Inexperienced nurses are concerned about organizing their work and distressed when they lose control of situations (Benner, Tanner, & Chelsa, 1992). In stable situations they derive security from routines and schedules, however, in unstable situations they lack flexibility to deal with rapid changes and unexpected demands.

In this study, preceptors emphasized being organized for several reasons. One reason was to complete all required work so orientees could leave work on time at the end of their shift. This involved finishing routine activities in a timely manner so that they would have time, if necessary, to deal with the unexpected. As a preceptor commented, "You never know what's going to happen in the next five minutes." Another goal was to help orientees keep on schedule with individual tasks so that medications, doctors orders, and procedures would be accomplished within professional and legal time frames. A third reason was so orientees would "look good" to others including doctors, peer nurses, supervisors, and patients. Preceptors emphasized that not being organized opened them to criticism. The importance of being organized was illustrated in a message conveyed to an orientee by her preceptor.

> Don't go to the phone and page the doctor if you don't have all the information ready. If you're going to call the doctor, make sure you have your flow sheet. Make sure you know what your vital sign trends or make

> sure you know what your urine output is ... Be prepared so that when he asks you a question you're not stuck on the phone going uh, uh, uh, I'm not sure, I don't know. Build up your repertoire so you can show him that you know your patient ... If you don't, it's okay to say I'm not sure, what specifically are you looking for and I'll track it down for you, but be prepared when you make that call, and you'll be surprised once you have all the information .... you'll feel a lot more confident about what it is that you are relaying to him, and it will only get easier and easier.

In the described situation, the preceptor gave information about how to be organized and made an association between organization of information and appearing like she knew what she was doing. She communicated the message that by being organized and having information at hand, the orientee would be able to answer questions with a sense of knowing the patient. In essence she was saying, you will look good to doctors, represent the patient well, and feel good about yourself if you are organized and can answer their questions.

Teaching Strategies for Organization

One cognitive strategy used to teach organization was to write out guides to remind orientees what they should be doing at certain times of the day or to reinforce verbal messages about what composed activities and when activities should be initiated. The approach was described by a preceptor.

> This is something that I do routinely with all the orientees that I have. Especially brand new nurses, novice nurses ... it's hard to start a new job and being a new graduate in a new place and not knowing anything or anybody or how things are done. I feel like my little lists, I make up on 5 x 7 cards, gives them some kind of lifeline, some kind of something that they can say, "Oh yes, I should be doing thus and so" or "I need to think about my documentation I haven't done my chem sticks yet or whatever." Just some kind of time frame to go by, it's nothing written in concrete, nothing written in stone, just some kind of reference so they feel maybe a little more secure like okay I know what I'm supposed to be doing now.

In addition to a list of the daily routine, preceptors developed lists for orientees about various routine duties including information to have available when ordering tests or supplies, what to include in shift report, factors to include in assessing a patient, and times for medication administration. Although lists

were "nothing written in stone", they were detailed enough to provide clear guidelines to keep orientees on track. The lists also served as memory enhancers for details that eventually would become habits and routines. Tasks that were conducive to list making were made easy and orientees could concentrate on aspects of learning which could not be listed on a piece of paper.

Another strategy preceptors used to promote organization was "dress rehearsals" that emphasized organization prior to real events (Figure 8). A preceptor described how she prepared her orientee to give reports to the next shift about the status of patients.

> Preceptor: I plan on sitting down with her about 2:45 and going over this data base and then I'll let her give me a report like she plans on giving to the evening crew ... we'll probably do that for the next several days.
>
> Interviewer: Why do you use that kind of technique for your teaching?
>
> Preceptor: I like to be organized. I think organization saves a lot of time and cuts down on the possibility of making mistakes. I find if you sit down and get your thoughts about you before you give [your] report, then you're more prepared.

Figure 8. Dress Rehersal: Preparing to Give Report to Oncoming Shift.

By utilizing dress rehearsals, the preceptor had the opportunity to promote organization prior to the actual event. The orientee was encouraged to demonstrate how she would give change-of-shift reports in an environment where the preceptor could provide feedback and make change in practice before it was witnessed by others. The rehearsals provided an opportunity to work out the problems before the orientee went on stage. By repeating the rehearsal over several days, the practice of reporting about patients could be refined and the orientee could gain confidence.

Another strategy preceptors used to teach organization was to stay connected by "touching base" with orientees during a shift to keep orientees on track. This strategy appeared during the third and fourth weeks of interviews, as orientees began to assume more responsibility for patient care. At the beginning of a shift, preceptors would encourage orientees to "plan their day and talk about it with me." During the day preceptors would watch and "check in" with orientees to be sure they were doing what they should be doing on time. Orientees reported, "if I don't look like I'm going to do it, then she goes ahead and lets me know...real subtlety...she'll point it out to me." Timing such comments ahead of scheduled events conveyed the message to orientees that organization required thinking ahead and could not be accomplished by waiting until the exact time something was due to be done. The observation and checking in increased orientees awareness of the importance of organizing their time and fulfilled the preceptors responsibility to patients by assuring that medications and treatments were given on time.

The message about the importance of being organized was realized by orientees. They also realized that "everything's just new and foreign to me now and I don't have enough slots for all this information." This feeling correlates with

research that shows that memory is selective, and, in new situations, learners must choose their focus (Ormrod, 1990). Since orientees do not have routine activities committed to memory as experienced nurses do, they would continually select a focus among everything that was new. If nothing unexpected occurred, then routine events could be focused on. However, if a diversion from the routine occurred, then attention may be focused on the unexpected. Understanding the role of memory in learning makes the oversight of the experienced preceptor important in terms of patient care. The experienced preceptor would recognize what was most important at a particular time and focus the orientee's attention in the most appropriate direction.

During third and fourth week interviews, orientees reported developing habits to promote organization such as, "I make out a sheet of when the meds are [to be given], when the labs need to be drawn..." and "What I'm starting to do is write down notes to myself on my sheet as I go through the day." When asked how she came up with such an idea, an orientee responded, " Because [the preceptor] has been telling me, 'Well did you chart about what the patient said about ...?' No, I forgot. So that's how I remembered the other things." Although orientees reported learning about organization from preceptors, they also felt that being organized was, for them, a personal trait. As an orientee explained, "Organization is something you have to, I don't know, it's a personal thing that is hard to [get from someone else], I'm sure you pick up on the way people do other things, but I don't know." In this regard, preceptors could assist orientees to expand on personal traits in their new work environment.

Summary of Teaching about Organization

Learning how to organize work was considered an important part of the practice of nursing and was promoted by preceptors. Preceptors connected being organized with "looking good" to other members of the health care team

and patients. Preceptors and orientees realized that inexperienced nurses needed assistance with and practice in organizing work and became stressed when unexpected situations interrupted planned routines. Getting off track was frustrating and challenged orientees to choose between tasks to decide the order of work to be completed.

To promote organization, preceptors utilized the teaching strategies of list making, dress rehearsal, and checking in with orientees during the day to keep them on track. List making established routines and schedules in a written format that orientees could refer to during the working day. Dress rehearsals allowed orientees an opportunity to show preceptors how they would perform tasks, such as communicating report to the oncoming shift. By refining techniques under the guidance of the preceptor, orientees could appear confident and organized in front of others. By checking in with orientees at intervals during the day, preceptors stayed connected and had the opportunity to help orientees make decisions about how to organize their work. Interview data revealed that by the third and fourth week of their preceptorship, orientees began to develop personal strategies to keep themselves on track and organized.

Teaching about Salience: A Basis for Establishing Priorities

The ability to establish priorities and organize work are closely aligned and are a part of the daily practice of all nurses. However, these abilities are different from one another. Being organized about work does not mean that an individual has arranged work in the best hierarchical order. During each shift, nurses make choices about where they will focus their attention and how they sequence aspects of patient care. The ability to make good decisions about what is most important at any one time is essential to patient care and safety.

As reported in her classic study, Benner (1984) discovered practice characteristics of nurses at different stages of development and revealed that

inexperienced nurses do not have a sense of salience about situations. Benner's research showed that new nurses look at patient signs, symptoms, and findings as equivalent pieces of information. As nurses become experienced, they are able to make graded distinctions about patient information and react to situations with a sense of what is and is not relevant.

In this study, preceptors and orientees recognized the importance of identifying priorities and understood that new nurses lacked this ability. A preceptor explained,

> With her (orientee) being a new RN, she recognizes that priority setting is the most important thing in nursing. She knows that it is one of her weaknesses because she is so new. This is where she's really trying to pay more attention to this."

Therefore, teaching orientees to think about and make good choices about "why something is important and why you do something when you do" became the goal of preceptors in relation to priority setting.

Strategies for Teaching about Salience

Teaching about salience was an intricate activity that was difficult to describe and break down into details. Therefore, teaching about salience was accomplished initially by using a combination of talking and thinking aloud and teaching by example. This technique was described earlier in the section on teaching about ill-defined, complex, and risky situations. Later, as orientees became more independent, preceptors challenged them and directed them in making decisions about how they arranged or did their work. In their teaching, preceptors expanded on the formal and practical knowledge that orientees possessed by using their own parallel experience to establish priorities for what to teach orientees.

The strategy of talking and thinking aloud and teaching by example did not differ from earlier descriptions. Preceptors verbally transmitted their knowledge

about establishing priorities by "explaining what's important and what isn't" and "by talking to myself out loud" as they worked with patients. In the early part of orientation, preceptors were very direct in their conversations about what was most important at the moment. Such an instance was described by a preceptor during a first week interview.

> At 1:00 she had finished two [telemetry] and one patient was due medication and treatment and she wanted to go give the meds. I said, "no, telemetry is more important. We're going to finish telemetry. He's [the patient] sleeping and stable, and this is more time constrained."

In this phase of learning, the preceptor recognized that the orientee made choices based on rules, in this instance related to schedules for medications and treatments. Varying from rules was "hard at first" for new nurses. Based on their experience of what was most important, preceptors gave permission and encouraged orientees to diverge from rule-governed practices in certain thought-out circumstances and under their close supervision. Conversations about establishing priorities enabled orientees to see situations from the experienced viewpoint of the preceptor. Since this viewpoint sometimes differed from that learned in formal education, preceptors needed to prove to orientees that their alternative way of seeing a situation was acceptable. This was possible through the trusting relationship that developed between preceptors and orientees and by the ability of orientees to test the message over time through personal experience.

Once orientees had begun to develop their own work patterns, preceptors repeatedly, but gently, challenged their decision-making about what they were going to do and when. This type of challenge was described by a preceptor during a fourth week interview.

> We'd find something that needed to be dealt with, and I would ask her, "what are you going to do?" She would tell me. It was then talking it out. "Is this something we can wait a while on? Or is this something you want

> the doctor to deal with now?" And when she said, "I want to deal with it now", I said, "Okay," and she went ahead...

The technique used by the preceptor caused the orientee to reflect on the situation and reach a decision about what was important. In addition and based on importance, the preceptor prompted the orientee to make a decision about what actions should be taken. By reflecting on the situation, establishing importance, and having her decision validated, the orientee could proceed with a sense of having successfully worked through a challenging situation. The preceptor placed the burden of responsibility for establishing priority on the orientee and made it her situation. However, by guiding her through the situation, the preceptor made it a learning experience, rather than one of trial and error.

Challenging, as a teaching approach, tests secure boundaries, widens the gap between the learner and the environment, and can be intimidating (Daloz, 1986). Therefore, challenging should be accompanied by support in order to promote development. However, learners can also experience a sense of pride in being able to work through problematic areas of knowledge, acquire new skills, and deal with unfamiliar situations (Brookfield, 1991). Such experiences can be transformational in terms of helping learners develop confidence in handling uncomfortable situations. By helping learners reason and question decisions and actions, they learn how to evaluate their performance, answer their own questions, and come to conclusions about how they are doing (Daloz, 1986). The positive impact of challenging and the way it was carried out was described by an orientee.

> She'll say, "Okay, what should we do? We still have a couple baths that need to be taken care of and now what time are meds due? Which do you think we should do first?" And I just sort of look up at the ceiling. I'll say, "well, we better get those meds out ..." She's making me think, but she's not letting me fall at all.

The conversation illustrated how the preceptor challenged the orientee to choose which activity was most important and deserved her attention first, giving a bath or giving medications. The preceptor relied on the knowledge of the orientee to make the right decision. However, her point was that in the moment a nurse is faced with doing two important things and one needs to be addressed first, how is the decision going to be made? The orientee became aware of her responsibility in directing her daily routine by making choices based on perceived priority.

The challenge in the example prompted the orientee to think; to think in a way that promoted reflection on the importance of the tasks at hand to reach a decision. Challenging exerts pressure on individuals and can cause uneasiness, however, it opens the possibility of looking at the world in a new way and causes people to consider their way of doing things within the context of a situation (Daloz, 1986).

The advantage of challenging for teachers is entering into the thinking of learners. In some situations, as described earlier, preceptors gave permission to orientees to vary from rules. Such permission can be risky and should be based on sound decision-making related to what is most important at the moment. Presenting challenging questions to orientees, such as "What should we do next?" and "Are you going to do A, B, or C?" was a way for preceptors to judge decision making in relation to priority setting. Such questioning could assist preceptors to made decisions about how much trust and independence they could afford their orientees in the area of priority setting.

Summary of Teaching about Salience as a Basis for Establishing Priorities

Interview data revealed that preceptors emphasized establishing priorities as an essential part of orientees' practice. To accomplish this, preceptors utilized talking and teaching by example during the early part of orientation. As the

orientation progressed, preceptors challenged orientees to explain and defend their thinking about what was most important and when. Challenging served as a strategy for the teacher and learner to interact and expose each others' thoughts to explain the what, why, and when of actions. Through challenging, preceptors were able to influence the rule-governed practice that is characteristic of new nurses and to expose orientees to alternative ways of viewing the priority status of situations.

Thus challenging produced advantages for both teachers and learners. Teachers gained access into the thinking of learners and were able to make judgements that affected decisions about what level of independence should be allowed. Learners gained insight into their ability to recognize the importance of aspects of situations and to see the experienced perspective of their teachers, thus broadening their own view of the world.

Interpreting the Picture

In the course of interacting with orientees, preceptors realized that what they saw and heard was not always the same as what orientees saw and heard. As a result, interpretation of situations was required. Interpreting involved reconstructing what inexperienced orientees saw and heard to heighten the meaning of events. The ability of preceptors to view situations with greater understanding was made possible by their experience in working with many similar patient care situations. By seeing and hearing the same events over time, experienced nurses were able to grasp meanings with a broader perspective than the inexperienced orientees (Benner, 1984). Not only did preceptors need to interpret events, they also needed to be able to recognize the differences in understanding, be sensitive to the orientees level of understanding, and present alternative points-of-view in a manner that promoted reflection and caused orientees to look at situations differently. Understanding what orientees were

seeing and hearing was important in order for preceptors to establish a baseline for building a learning experience. Judgments and actions are framed on the sense we make out of and the way we perceive situations. Therefore, the more accurate our interpretation of situations, the more appropriate and meaningful our responses will be. Helping orientees to build on what they saw, to expand their vision and hearing, was a goal of preceptors.

Making the Invisible Visible and the Unheard Heard

During interviews, both preceptors and orientees related incidents where orientees did not see or recognize the meaning of signs and symptoms. Such a situation was exemplified in a story told by an orientee about an experience in which she and her preceptor cared for a dying patient.

> I could look at him and tell he looked pretty bad, but I had no idea how soon ... When I came in this morning, he seemed a little more responsive. We pulled him up in bed and he startled and his eyes opened. When you'd call his name, he would respond. His family was in and out of the room today, so I didn't hang around in there. I just did what I absolutely had to do...[the preceptor] and I were going to do AM care, so the family left the room...[the preceptor] was saying things on the side like, "We need to get him cleaned up for his family to get to see him one more time." Saying things with some finality to them...She was telling me. "He's right there ..." he looked really bad ... But he had seemed almost that way yesterday...

In this example, the preceptor had experienced the deaths of many patients. She recognized signs that indicated the patient was on the brink of dying and directed her actions to make the experience as kind as possible for the family. The orientee was inexperienced in caring for dying patients and did not pick up on the same cues. What she was saw was different from what the preceptor saw. The preceptor understood this and attempted to enhance her vision by giving her cues to indicate what the reality of the situation was and where actions needed to be directed. In some situations, knowing what to do is obscure "because the teacher is holding a perspective the student has yet to develop" (Daloz, 1986). By sharing her experienced perspective, the preceptor

sharpened the orientee's vision and also guided her in knowing what was important in the situation.

In another instance, a preceptor described hearing a different message than her orientee.

> This morning when the patient was telling me he had chest pain. I don't know if she was aware of what he was saying because the patient doesn't always say, "I have chest pain all the time." He was saying, "Oh, I feel lousy today and I just don't feel good." And I don't know if she was really hearing that and so I kind of had to draw her into the conversation and say, "How long has this discomfort in your chest lasted, when did it come? On a scale of zero, which is nothing, and ten, which is the worst you could stand in the world." I tried to draw her in and let her know that this was something that you need to do.

In this instance, the message communicated by the patient was perceived differently by the preceptor and orientee. Because of previous similar experiences, the words, "I don't feel good" had a different meaning to the preceptor. The preceptor, who knew the patient, was able to reflect on the words and arrive at a message that had a much broader meaning and opened up a whole different communication with the patient. To enhance learning, the preceptor brought the orientee into the conversation and gave her clues to reflect on. The clues were intended to help the orientee hear not only the words, but the meaning they had for the patient. By drawing the orientee into the situation, the preceptor introduced the orientee to the situation and engaged her in coming to know how to attend to patients through their conversations. Had the preceptor not been present to interpret the communication, the orientee would missed out on a valuable learning experience and the meaning the message had for the patient would have been lost.

Summary of Interpreting the Picture

In the course of teaching, preceptors encountered situations where inexperienced orientees did not see or hear the same things they did. In an effort to enhance orientees' awareness, preceptors interpreted the situations by sharing

their sense of what was happening, made possible by their experience and increased understanding. The alternative way of viewing happenings prompted orientees to reflect on what they saw and heard from the advantage of an experienced more meaningful perspective.

CHAPTER VI
THE TACT OF PRECEPTING

Three patterns and associated themes that define the tact of precepting will be described in this chapter: (a) transitioning orientees into a new work environment, (b) safeguarding the patient and orientee, and (c) balancing the demands of caregiver with preceptor. While the preceding chapter described the domains of teaching practices preceptors used to help orientees learn how to perform skills and handle situations, this chapter will describe how preceptors practiced "the tact of teaching" (van Maanen, 1991) or in this case, the tact of precepting, to understand, initiate, and safeguard orientees while balancing the demands of caring for patients. Van Maanen (1991) describes tact as an ability to be oriented and sensitive to learners in a way that enables teachers to take mindful actions in situations. "A tactful person seems to sense what is the right thing to do" (van Maanen, 1991, p.126). The ability for mindful action is developed through a process of thoughtful reflection on past teaching experiences in order to enrich future experiences and develop a "pedagogical fitness" (van Maanen, 1991, p.205).

Pedagogical fitness is defined as "a cognitive and emotional and moral and sympathic and physical preparedness" that manifests as a mindful orientation to learners (van Maanen, 1991, p.205). Thus tactful teachers have the sensitivity, resiliency, and intellectual knowing to understand situations, to interpret the significant meanings, and to sense what their role should be in terms of entering in or distancing themselves. In this study, tact was an important

aspect used by preceptors to assist orientees to make a safe transition into their new work environment.

Transitioning Orientees into a New Work Environment

Data from both preceptors and orientees revealed a recognition of the vulnerability and turmoil that characterized the practice of nurses who were starting a new job and were unfamiliar with their new work environment and expected practice. Understanding what orientees were experiencing was important for preceptors as a basis for their actions and practice. Just as nurses assess patients in order to diagnose their problem, preceptors sought to assess and understand what orientees were experiencing in their world of being new.

Understanding being new was also important for orientees who have been described as frightened, anxious, and vulnerable. Although their feelings were internal and could only be fully realized by themselves, orientees were not alone in terms of being understood, supported, and protected. This section will describe how preceptors acquired an understanding of the experience of being new and how they responded through tactful practices.

Acquiring a Perspective of Being New

Throughout the data, preceptors revealed acquiring insight into the vulnerability of the orientee in relation to their being new and inexperienced. Just as orientees recognized capability differences between themselves and their preceptors, preceptors understood and described what it meant to be new while developing practical knowledge. Their perspectives were gained from many sources including memories of their own past experiences of being orientees and insights gained through past precepting experiences. These insights have been described in Chapter IV. Preceptors also recognized what it meant to be new by placing meaning on the information they processed by watching, listening to, and working with their orientees. Preceptors described being constantly tuned in to

their orientees and what they saw and how they handled the uncertainty of being new led to their understanding. It was in response to the messages received from orientees that preceptors directed their courses of action. As described by a preceptor, "What I'm trying to do is get a feel for this early stage of how a new nurse behaves and what kind of teaching they require or what kind of backup they require." Preceptors oriented themselves to what was happening to orientees by "the look on her face", "keeping my ears open", and using "body clues." One preceptor/orientee pair talked about being able to "just look at each other" to communicate when the orientee was in trouble and needed help. Through their watchfulness preceptors described being "able to see whether she seemed comfortable" or "she had a grimace on her face...I don't realize how fast I move and how I bounce from one thing to another. She wasn't used to that pace..." Being mindful of the experience of the learner, helps to form close associations where teachers care about how learners feel and direct their actions with understanding of what the other is feeling (van Maanen, 1991).

Because of the unpredictable environment of the study settings, the ongoing status of an orientee's feelings and emotions could never be counted on with certainty. One minute, conditions could be stable with the orientee feeling comfortable and the next minute a patient's condition could have changed and the orientee be in trouble. A preceptor described such a situation where a patient's condition "declined within a matter of moments."

> [The orientee] had been steadfast at the bedside up until that point in time when we were swarmed by a medical team ... along with anesthesia. And telepathically we were able to pick up on each other and I could see that she was starting to become overwhelmed and she stepped back and I stepped in ...

As a result of the unpredictable environment and consequently a narrow margin of error, preceptors had to be vigilant and exercise choices of what action to take to facilitate learning. In the preceding instance, the preceptor could have

left the orientee in the situation to learn by trial and error, gone into the situation to join the orientee, or gone the chosen route of taking over for what she saw as an overwhelmed orientee. Later in the interview, the preceptor explained that her decision was based on the fact that she considered "it a normal process for her [the orientee] to go ahead and step back at that point and that she would feel in her progress that she would want to step forward the next time once her skills were stronger." Her decision displays a sense of thoughtfulness and insight into what the effect could have been if the orientee had been left to handle a situation for which she was not prepared. The preceptor related, "I don't want her to experience any kind of low self esteem. I want her to feel confident with what she knows ..." The preceptor based her decision on her experience and directed her actions to protect the orientee from what might have been uncomfortable and made her look incompetent to colleagues.

The experience of being new is exemplified in the following narrative in which a preceptor described an experience that occurred during the third week of orientation when she and her orientee responded to a patient with chest pain. While the experience exemplifies many of the tactics described in the section on teaching and learning, it also exemplifies the tact used to respond to particulars of the situation that related to the actions of a new nurse.

> This was the gentleman yesterday that really kept us busy in the morning ... As soon as he said he had some chest pain, she [the orientee] said, "Should we call the doctor?" I said, "No, there's things to follow before you call the doctor. With giving the nitroglycerin and taking a set of vitals, and unless the patient looked like he was going to code on us, that we don't call the doctor until after at least the third nitroglycerine." The one thing I saw with her, I guess because she's a novice, after she gave him the first nitroglycerin, she took the nitroglycerine and put it back in his med drawer instead of leaving it at the bedside or in her pocket. I told her if I have a patient who's having chest pain, I just leave them in my pocket and note the time that you give it. You are explaining to him to use the pain scale of zero to ten. Then each time before you give the nitroglycerine, you assess the pain level to see how much it has gone down. In his case after the third nitroglycerine, he said he was still at level six which is pretty high.

> His vital signs were taken also and the vital signs were fine. We had raised the head of his bed, and his wife was sitting there. After the third nitro, I let her page the doctor and she talked him. I said, "before you page, get your thoughts together about what you're going to say. You don't want to sound confused or disoriented yourself." She jotted down what she had done. She explained everything to the doctor and asked him to come and assess the patient, and he gave her a phone order for Tylox ... When she got off, she told me what he said, and I said, "We have a problem. We don't have Tylox in this hospital." She felt bad. I said, "It's not a problem." Instead of calling him back, there was another doctor from the same team on the unit at that time, and I said, "We got a phone order for two Tylox. How about giving us an order for two Percocet instead?" I had called pharmacy and found out what they substituted for the Tylox. The other doctor gave me a verbal order and I got him to sign his verbal order and we gave the patient two Percocet and it did relieve him some. The doctors came over and did an EKG, and there weren't really any EKG changes and then they called in the renal doctors. With his renal problems they were afraid he was going into acute renal failure. That's exactly what he did. She was quite busy with that. One time after she started to write notes, and she had actually written one line and then I said we have to go back to the patient, we don't have to do the note right now. One of her concerns was what if someone picks up that chart and starts writing on the next line. I said, "You can grab the progress note out of the chart and put it in your pocket. But you can always go back to the chart, you can always scratch through that and start over. The most important thing is being at the bedside with the patient." It was a good learning experience for her.

The above narrative illustrated the vulnerability of the orientee in a situation where she lacked practical knowledge and the concernful practice of the preceptor in guiding the orientee through the situation. In her formal learning, the orientee would have learned what caused chest pain, how chest pain was traditionally treated, what the mechanisms of medications were and how important it was to document interventions. However, the difference between the theoretical knowledge and the practical knowledge was apparent to the preceptor. The preceptor understood the actions and responses of the orientee as characteristic of being new and responded to her need to gain practical knowledge by sharing her own knowledge and guiding her through the situation. The way the preceptor handled the situation does not depict a hierarchical relationship between a teacher and a student, but rather as a person guiding a

peer through the learning process. Instead of being concerned about herself, the preceptor was there for the orientee and the patient. Being there for and with the orientee was broader than being a nurse taking care of a patient with chest pain. Now the role of the nurse was expanded to that of a preceptor, teaching an orientee to handle a situation and maintaining an awareness of the person behind the teaching, in this case the patient. "In this sense, tact is the practice of being oriented to others" (van Maanen, 1991, p.142).

The narrative also describes how an understanding of the orientee's inexperience guided the preceptor. The preceptor was able to see where the orientee was and where she needed to go. She aligned herself with the orientee and provided structure as she took her through the steps to resolve the patient's chest pain. When the orientee got into trouble by taking an order for a non-formulary medication, the preceptor recognized the orientee's feelings. Seeing herself as being there for the orientee, she took the trouble on herself. This choice was in preference to having the orientee call the doctor back and appear as new and unknowing. If there was to be blame, the preceptor accepted it as hers.

The preceptor, however sensitive, remained strong in her affirmation of what needed to be done and where attention needed to be directed. "A tactful person must be strong, since tact may require frankness, directness, and candor when the situation calls for it" (van Maanen, 1991, p.125). When the orientee directed her attention away from the unstable patient in order to follow the learned rule of documenting events as they occur, the preceptor firmly taught her about salience. She arranged the order of events in the hierarchical order of patient first, chart later. The situation illustrated how teaching about the status of the patient was more important than teaching about skills or routines. Teaching

the guidelines for treating chest pain was important, but recognizing and responding to the person who was having the chest pain was essential.

The lessons derived from this situation could only be learned through experience and not from textbooks and lectures. Textbooks and lectures can teach new nurses to obtain a doctor's order for a pain medication in response to a patient complaint but not what to do if the doctor orders a non-formulary drug. Practical lessons can only come from learning the rules of actual situations and reflecting on them through experience. However, the risks associated with being new and gaining experience in a hospital required tact to promote learning through this vulnerable, tumultuous period.

Responding to the Experience of Being New: Moving Orientees Forward

Although preceptors realized the importance of understanding and being patient and sensitive to the feelings of orientees they also realized they had a limited period of time to transition the orientee into the new work environment. Therefore, they needed to constantly develop strategies to move the orientee forward in learning at a comfortable, yet steady pace. Preceptors strategized for learning by tracking where orientees were, where they should be, and where they needed to go. Knowing where orientees were involved tracking what responsibilities they were becoming safe and comfortable with, what they were unsafe or struggling with, and how they were progressing overall. Having this sense of knowing directed preceptors in what topics or areas they selected for teaching, how hard they pushed or pulled the orientees into situations, dictated the level of independence they afforded their practice, and guided them in choosing what role they needed to provide on a day to day basis.

Preceptors had a sense of where orientees should be in the learning process from past precepting experiences. Past negative and positive experiences provided a basis for knowing how the learning journey should

proceed toward a targeted outcome in terms of learning ability, safety, motivation, and concern for patients. During interviews, several preceptors described previous precepting experiences where difficulties had been encountered and where learning had gone well. This background provided a basis for comparing the performance and progress of assigned orientees and for making judgments about how to plan and proceed. The determination of where orientees needed to go was based on knowledge of what was needed to care for patients in individual settings. During this study, orientees proceeded at what preceptors considered a normal or accelerated pace and no learning difficulties were discussed during interviews.

Comments made by preceptors during interviews about where orientees were in the learning process were both specific and general in nature. Specific comments included, "She still has trouble approaching the physician", "I feel she is safe in giving medications", and "She's still at a novice level as far as being able to assess a patient." General comments included, "She's still trying to juggle everything", "She's still a novice nurse, even though she's at a higher level than other nurses", and "She's refining and adjusting her practice and incorporating it into her new unit."

Preceptors demonstrated understanding and patience in knowing where orientees were in their practice and knowing what they needed to do to overcome feelings and behaviors. Comments such as "he forgets some things" were followed by comments that reflected what was best for the orientee such as "he still needs some coaching on that." "It's from being brand new" was followed by "That's why they need us ..." Many comments were related to the normalcy of a developmental phase such as, "I think he's still centered on his patient only and that's going to be for quite a while" and "she knows everything, but she doesn't know how to put it all together yet." Such non-judgmental comments

demonstrated a knowing of the usual and ordinary in terms of the formative stages that orientees evolved through as they learned.

Preceptors also recognized where their orientees were in terms of their strengths and potential to be "a good nurse" or "safe practitioner." Many times needs were framed within the context of strengths. As a preceptor related, "She has good IPR [interpersonal relation] skills. She's observant. As far as fine tuning assessment skills, that will come with time." Strengths were mainly related to personal attributes such as, "she very motivated, wants to learn", "She's a very conscientious person, she gives a lot of thought before she does things", and She's a very caring individual." Such attributes were related during all four weeks of interviews and indicated confidence in the orientee to grasp learning and succeed in their new position. During the four weeks of this study, preceptors described the needs of their orientees alongside attributes indicating an ability to succeed in their new jobs.

The Role of Planning in Facilitating Transition

The consideration for feelings, needs, and strengths in combination with the changing demands of the hospital environment created a complex situation for preceptors to plan for learning. Learning situations often appeared unpredictably and had to be taken advantage of on the spot. An orientee reported putting together a calendar to plan what kind of patient assignment she and her preceptor wanted each day, but as she reported "it really doesn't work. You can't always pick the patient you want." The opportunity of caring for patients with needs critical to practice impacted on the length of the orientation period. If orientees had an opportunity to learn to take care of patients who would be typical of their patient population, their training would move along. However, if a segment of that patient population rarely presented, then the orientee's training would be lengthened to await the learning opportunity. This

was particularly true for the intensive care units where the number of patients cared for was less and therefore, opportunity was decreased. The impact for opportunity was illustrated by an orientee who responded to a question about the length of her training, "I'm not looking at time as much as I'm looking at the experience I'm getting. I'm not sure when they're [unstable patients] going to come in."

In part, preceptors used a checkoff list to plan and track progress. The forms were reviewed periodically and as reported by an orientee, "we go over my self-evaluation tool and that gives her [the preceptor] a good idea of what I need to practice with." While the checkoff lists provided a formal mechanism to track progress, informal planning was utilized on a day to day basis to transition orientees to their work environment.

During interviews, preceptors related what their weekly plans were to help the orientees gain experience that would enable them to be comfortable with unit routines and to handle the more common unexpected events. The plans included repeating and perfecting work which had already been learned, moving into unfamiliar areas, taking advantage of the unexpected, and preparing orientees with knowledge about resources to survive beyond the orientation period. Comments related to planning made by preceptors included, "I want her to start participating in disposition planning ...", "trying to get her to be more aware of what's appropriate for this patient and writing it down. That is my main goal for the next week or so", "We need an active GI [gastrointestinal] bleed. We need someone we're slamming blood into, bedsides full of people and working through that chaos", and "I just want to make sure she knows where she can find answers that help, from people, books, telephone. She'll always have someone to fall back on." Such comments demonstrated that preceptors had a vision of where they needed to go in terms of teaching about patient care and also in

teaching about resources that would provide backup for orientees when they were not available.

Planning for future teaching scenarios, assisted preceptors to anticipate their role in the learning process. Moving in and out of both familiar and unfamiliar situations, sometimes within an eight hour shift, dictated that preceptors be flexible and watchful as to where orientees were in terms of comfort and discomfort and what was safe. As described earlier, at one point in time preceptors may have been standing on the outside observing the orientee's practice and within a matter of minutes the patient's condition could change and the preceptor would become the primary caregiver, with the orientee as observer. Thus preceptors had to plan for the unplanned and rely on their tact to provide insight into the needs of the orientee and the situation.

Summary of Transitioning Orientees into a New Work Environment

Teaching orientees was accomplished by the concernful practices of preceptors using tact. The "tact of teaching" (van Maanen, 1991) was directed toward understanding and responding to the phenomenon of being a new nurse in an unfamiliar environment. The tact required to assist orientees to transition to their new environment involved understanding what it meant to be new and responding to the understanding by moving orientees forward in the learning process and planning how to get the most learning out of situations.

Understanding was gained by reliance on past experiences, comparisons with other nurses, and by processing the verbal and non verbal messages sent back and forth betweeen the teacher and learner. As preceptors came to know and understand the orientees, they gauged where orientees were in the learning process, where they needed to go, planned for the expected, and took advantage of the unexpected. Knowing where orientees were was based on the preceptors past experiences that provided them with an understanding of normal learning

progress. This knowing guided preceptors in their planning. Exact planning, however, was difficult because needed patient care opportunities were not always available. Therefore, preceptors took advantage of situations as they occurred and maintained a perspective of what orientees needed to become knowledgeable and safe to care for patients.

Safeguarding the Patient and Orientee

Being a new nurse in a hospital setting poses risks to both patients and orientees. Elements of patient care are fraught with danger and a mistake can be life threatening. Errors in elements of patient care may involve both omission and commission; medication and treatments overlooked or administered incorrectly can lead to serious consequences. Professional practice also includes a legal risk. All professional nurses are legally responsible for their actions and responsibilities to patients. Failure to perform their expected duty that results in harm to patients, regardless of status or experience, can result in professional discipline and legal tort.

Previous sections of this study have shown that orientees lacked the practical knowledge and experience needed to work in their new work environment. Even though they had successfully completed formal education and may have some previous work experience, they lacked practical knowledge unique to the new environment, the kind of knowledge that comes with practice (Jarvis, 1992). "Every practical work situation provides a potentially new experience from which to learn ..." (p.188). Acquiring practical knowledge can only come about with experience and the learning associated with it. Learning from experience can be fraught with errors because decision-making may be based on "faulty reasoning, personal projections, and taken-for-granted beliefs that have not yet been tested" (Ellerington, Marsick, & Dechant, 1992, p.52). Therefore, monitoring learners in situations where there is a narrow margin of

error is also a matter of ethics. While learners should have freedom in the educational process, help and guidance are required when people who are disadvantaged are involved (Jarvis, 1992). In hospitals, many patients are at the mercy of their caregivers. Mental or mobility status and lack of knowledge of treatment modalities prevents patients from realizing their best interest. As a result, healthcare organizations must assume responsibility for providing mechanisms to protect their disadvantaged consumers.

In the hospital setting, preceptors provided a safe method for orientees to learn and practice new knowledge and skills. Thus, the role of the teacher was much broader than that of transmitting knowledge and skill. Preceptors also became the safeguard for patients and orientees. Safeguarding in this study refers to the protective actions gleaned from data that preceptors utilized to provide the expert oversight and backup for a safe learning environment. On a broader scale, precepting also safeguarded the profession of nursing by monitoring those who could affect the reputation of a group through mishap or poor judgment. Thus, safeguarding through precepting demonstrated a stance of caring that showed concern for individuals and the profession.

Data revealed that preceptors accomplished safeguarding by moving in and out of situations to provide both learning and "just the right amount" of supervision. When preceptors moved into situations to safeguard, they were teaching in combination with checking on, reminding, and sometimes rescuing. When preceptors moved out they were fostering independence, testing knowledge and skills, and demonstrating trust. Their movement in and out of situations was effective because even when they moved out, they were watchful and available should problems arise. Although the art of moving in and out of situations was described to some degree throughout interviews, it was more prevalent during third and fourth week interviews as orientees began to gain

independence in their roles. This was particularly true on medical units where visibility of orientees was limited to a greater degree than in ICUs. This section will describe what considerations impacted on decisions to move in or out of situations, how preceptors aligned themselves to realize when to move in or out, and what actions they took and purposes they served when they moved in to safeguard.

Considerations for Gauging the Boundaries of Practice

The role of safeguarding the patient and orientee demanded constant decision making related to how much supervision and assistance orientees required. Preceptors described wanting to let orientees do as much as they could in order to give them "some sense of accomplishment," yet realized that this required consideration of many factors related to each situation. These considerations included the patient's condition, available time, where orientees were in the learning process, and the cognitive realization by orientees of what needed to be done. An additional factor necessary to safeguard the emotional status of the orientee was the willingness of the patient to participate in the learning process.

The consideration of safety for the patient took into account acuity status and care requirements, which dictated the level of knowledge and skill required for safety (Figure 9).

The difference perceived between the level of skill required and the level of skill possessed by orientees directed the preceptor's presence or absence. As an orientee related during a fourth week interview,

> If we have a patient that's rather technical and needs a lot of output and a lot of chest PT and lung procedure type stuff, she sticks more closely by me than she would for someone who just needs some suctioning here and there and needs his meds given to him and just needs to be turned. She'll let me do whatever I need to do.

In some situations the preceptors' judgment warranted staying in a situation, and in others they would move in and out as they deemed necessary. As a preceptor described,

> When she got her first admit and I'm in there. I'm not leaving her by herself. And then I pull back a little bit and go to my patient...and she's pretty much handling it, but then I'm there again. I'm in and out.

These examples depict how the in and out movement of preceptors was an open-ended supportive response to patient and orientee needs. Rather than being in *or* out they were in *and* out, an important discriminating factor. Guided by their embodied realization of what was right for the patient and orientee, preceptors' movements provided the presence or absence needed to protect, learn, and grow.

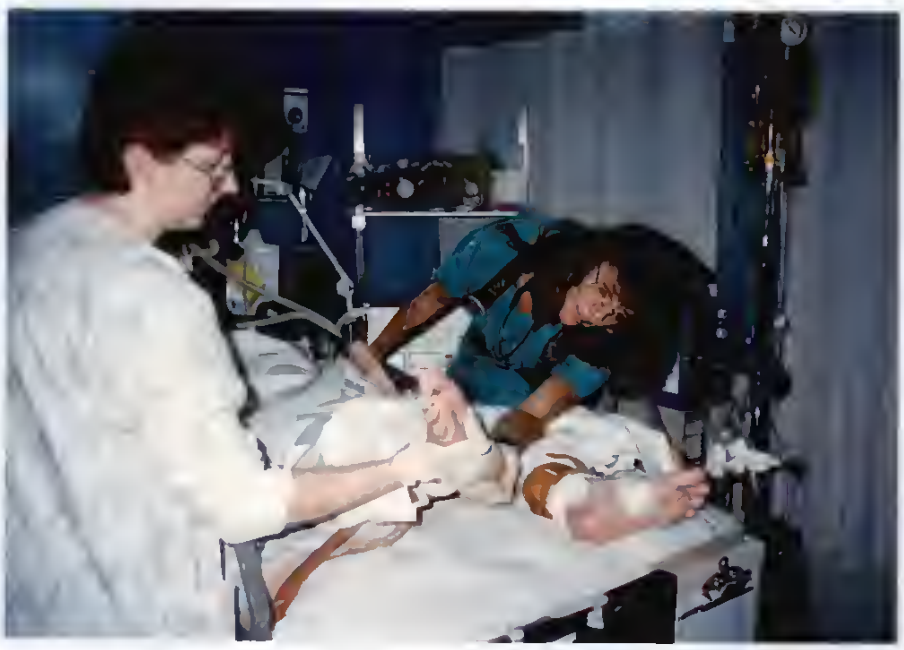

Figure 9. Working Together with an Unstable Patient in the ICU.

Available time was also a consideration for movement in and out of situations. As a preceptor explained, "If it gets too busy, I might just kick into another mode and say, just watch me. Let me do it, because I've got to get it

done, and I'll explain it either as I'm doing it or right afterwards." The consideration for time was usually explained in terms of to the patient as, "I have to put the patient first and then her [the orientee]." By putting patients first, preceptors demonstrated responsibility for the interests of patients.

A third consideration was where orientees were in the learning process. As mentioned above, preceptors wanted to give orientees a "sense of accomplishment" achieved by "the best way is to stay back." So, as a preceptor explained, "If I think that she's doing fine, I just stand back." But until preceptors "felt comfortable that she could do it...," they would watch and be there. In order to give orientees as much autonomy as possible, preceptors would encourage them to do as much as they were able to do, and they would take over elements of care they had yet to learn. This was expressed by an orientee as, "I was doing the physical labor, ya know, giving meds, doing procedures on them...stuff like that...it never seemed like she was there, but she was looking through the chart...or the med book..."

The learning level of the orientees related in part to their comfort level. As an orientee explained, "She'll always ask me if I feel comfortable doing something. If I don't, she'll do it for me and tell me to watch." This consideration for the comfort of the learner indicated that preceptors were sensitive to feelings associated with learning and were willing to extend themselves to reduce discomfort. The fine line between comfort, knowledge, and the least amount of supervision possible was considered constantly as preceptors moved in and out to safeguard.

A fourth consideration for moving in and out was closely aligned to the learning process: knowing or remembering what needed to be done. In this early phase of learning, it was difficult for orientees to organize their work so that all the details of patient care were remembered. How much they remembered

impacted on movement in and out of situations. This consideration was described by a preceptor as,

> When I feel that she is doing the right thing and is capable of doing the right thing and knows the right thing, I just stand back, but when I feel maybe she doesn't or maybe she's missing something, or she may miss something, I just step in.

Preceptors reacted to forgetting or as they termed it "missing" elements of patient care as developmental and expected. Orientees sensed their understanding and appreciated the reminding in terms of safety. As an orientee stated, "I'm glad she's being cautious, cause she's caught me a couple of times." They accepted the fact that "if there is something I forget to do, then she'll tell me."

The final consideration related to the attitude of patients toward learners. In a teaching hospital, patients are usually receptive to learners, however, occasionally a patient will object to being cared for by a new nurses or staff member. Such an episode occurred on a day when the preceptor was ill and was described by the orientees as an unpleasant experience.

> And it was a bad day ... I took care of the patient all morning, and around eleven o'clock his heart was going a little fast and they wanted to give him a little Cardizem .... And [the nurse I was with] was kind of explaining all of that to me, and the patient heard her explaining that, and picked up on that I was new and learning and I went away from the bedside for a minute and I came back and I heard the patient saying something to [the nurse]. I heard [the nurse] saying, "Well, she's new, but I'm here to oversee everything she does." Well, it kept getting worse and worse by the minute. The patient started snapping at me, and I was sitting on the bedside ... and he would ask [the other nurse] to do something when I was right there .... it really hurt my feelings and .... then [the nurse] came back and put her arm around me and said, "Are you okay?" And it made me want to cry. I just didn't want to start crying and so I just was like, "No there's something in my eye", you know.

Avoiding situations such as the one described was important to preceptors to preserve the confidence of learners. Preceptors realized that they might have to "stop her and correct her or something like that in front of a patient" and this

might be an issue for the patient. Therefore, they attempted to select patients for teaching who they thought would be receptive.

Gauging When to Move In and Out

It has been described in previous sections how preceptors used their senses to determine how orientees were doing in the learning process. This was also true for gauging when to move in and out of situations. Through watching, listening, and being aware of activity, preceptors were depicted as having a keen sense of where orientees were, what they were doing, and most of all when they needed assistance. In fact, preceptors operated as if they had antennae that were tuned into and received messages from the orientees. Preceptors explained, "I'm not with [my orientee] all the time, but I think I know where she is all the time" and "I'm maybe down the hall doing something and I realize that she is doing her meds now, and it's the time to do the meds .... So I know she's taking care of that." This keen sense of awareness helped to sustain a learning environment that promoted independence, yet provided a mechanism for prompt detection of problems.

The manner in which preceptors monitored orientees was sensitive and discerning. Preceptors did not want to appear as "hovering over" orientees and, therefore, they "observed her from the side, without her knowing that I'm there, or at least I'm hoping that she doesn't know ..." or "I'm just observing her at a distance at this point." One preceptor described how she would "just run into her [orientee] and I'm trying to let her go, but I want her to know that I'm there."

While preceptors described being unobtrusive in their monitoring, orientees were aware of and grateful for their watchfulness. They described the watchfulness as "keeping an eye on me" and "she's the invisible shadow." As an orientee explained, "She just keeps her distance, but she's right there in the unit somewhere. All I have to do is scream and she'll be there. So it's a nice safety

net to fall into." Orientees interpreted the distant watchfulness as "showing trust in them as a nurse." The preceding comments from preceptors and orientees indicated how available preceptors were to orientees. Even when orientees were working with their own assignments, preceptors were ready to jump in if they perceived the need or the orientee stated a need.

Based on the messages preceptors received from orientees and the environment, they decided whether and when to move in or stay out of whatever situation the orientee was involved. What preceptors did when they were in and out will be described next.

The Strategies of Moving In
Checking on

Taking care of patients is very detailed work, some of which is dictated by a schedule and some of which is dictated by standards of care. Medications and treatments are administered by schedules and must be given on time in order to meet legal standards. The status of the patients must be ascertained at regular timed intervals and may involve physical and/or hemodynamic assessment. Patients are admitted, discharged, and prepared for and transported to procedures at set times. During a shift, physicians write orders which must be transcribed and carried out within timeframes. In addition, patients must be bathed, fed, mobilized, taught, and cared for emotionally. While these latter activities are not dictated by time, they are equally as important for health and well being.

As orientees entered into their new positions, they gradually became responsible for all the care requirements for a patient or group of patients. Remembering what to do within scheduled time frames was difficult, particularly since orientees took longer to do work which was unfamiliar. Preceptors were aware of the complexity of getting required work done on schedule and

understood the risk of not having it completed. Therefore, as a part of safeguarding at this stage of learning, preceptors moved in when necessary to check on and ensure that both orientees and patients were safe from errors of omission and commission. Preceptors checked on orientees openly and honestly to create an environment in which orientees could practice to the best of their ability and know that, if they forgot an element of care, it would be noticed by their preceptor. By creating a safe environment, orientees were able to take on new responsibilities, trusting that their preceptors would function as backups. Preceptors made their purpose clear and viewed checking on as a necessary element of learning. Just as growth means looking ahead, it also means looking behind to use history as a reminder for what should have been.

Preceptors checked on orientees to ensure that both specific tasks were completed and to ascertain how orientees were doing overall (Figure 10).

Figure 10. Checking on An Orientee's Documentation.

With regard to specific tasks, preceptors related, "I checked up to see how often she'd done her vital signs" and I went behind her today and just picked up the bedside charts just to see if she had followed through and documented, and she had." Generally, preceptors would check with orientees at least "every couple of hours." A preceptor reported, "I try to check up on her often. If she hasn't come around and asked me any question...I try to say, "How you doing? What's up? Everything Okay?, Need anything?"

Orientees were very aware that they were being checked on even if they didn't see preceptors doing it. As an orientee explained during a fourth week interview,

> [The preceptor's] checking behind me. I never see her do it, but I know she is. This morning [she said], "Did you give the meds to beds one and two, yet?" How did she know that? How did she know I haven't done that, yet? She's checking behind me. She's asking me, "Did you remember to chart that so and so said he felt dizzy? Did you remember to chart there was oozing on that dressing?" Shoot, no. She's asking .... She never has made me feel stupid for forgetting something or being behind with something. It's nice to know that she's checking on me and she hasn't completely let me flop.

This description illustrates how checking on was accomplished for the good of the patient and the orientee. Checking on not only provided learners the opportunity to become safe practitioners by experiencing their new role, but it did so in the interest of the patient. Thus in the interest of the patient, safeguarding in the form of checking on was legitimized as an educational approach. Instead of being viewed as a punitive, oversight measure, checking on was viewed as a practice that provided learners the freedom to learn in a system where people must be protected. By assuming the role of safeguarding in the form of checking on, preceptors exercised their responsibility for the broad role of precepting that included not only teaching knowledge and skill but establishing a safe environment for the patient and orientee.

Orientees were appreciative of being checked up on and realized the importance for patients. An orientee related, "I tell her, [name of preceptor] I'm so glad you caught that. Thank you so much for preventing that problem that would have happened if you had let me forget that." The remark indicated a conscious awareness of the importance of patients' safety. Many similar appreciative remarks by orientees demonstrated that while they lacked a sense of salience about patients signs and symptoms, they had a sense of the importance of their overall well-being and wanted to do right for them.

While orientees were aware of, realized the necessity of, and appreciated the fact that they were being checked on, they also had feelings that related to their being new and forgetting. Such feelings were described by an orientee who told about forgetting an order for a blood draw.

> I guess by the time it's [orientation]over with I'll be as good as I can be. Little things happen from time to time that make me wonder how many errors I'm going to have when I'm on my own. This patient that just died, yesterday, they wrote an order for a stat potassium draw and I signed it off, but maybe an hour later [preceptor] started looking at the lab labels, and that we need to page the IV team. I was thinking I never would have given it a second thought. I would have let it go because usually the secretary has signed that the lab things are taken care of. I just went back and initialed behind it and signed off whatever meds. I didn't say anything to her about that, but little things like that.

The described situation not only revealed how the orientee realized she had failed to follow up on an order but gave insight into her feelings and responses. Being "as good as I can be" was not viewed as good enough. Being new and making errors meant experiencing the feelings that go along with realizing one has made a mistake. The preceptor's choice of correcting the error herself neither made the situation better or worse. The action itself made the orientee realize that she had a ways to go to become good enough.

The outcome of checking on orientees was based on an understanding of a situation and, as a result, what preceptors felt was right and good for the

orientee and patient at the moment. In many instances, the outcome was no action. In other situations, in order to safeguard, preceptors decided to move into a situation to remind or rescue.

Reminding

A natural follow up to checking on was reminding. Preceptors reminded orientees that they had forgotten an aspect of care with the intention that orientees would realize and then do what they had forgotten (Figure 11). First and second week interviews indicated that preceptors would do some forgotten tasks themselves in order to allow orientees to keep on track with work. However, if the task was important enough or if the purpose was to prepare for independence, preceptors would remind more and assist less.

Figure 11. Reminding an Orientee How to Complete a Form.

As a preceptor explained during a fourth week interview, "I didn't go to her as much as I have in the past. That's what I've been doing with her with

medications, ... watching her without her knowing it, ... making sure she's staying on time...but just letting her go for it ...."

Reminding for the most part was put in the context of the patient. Preceptors would emphasize the importance of not forgetting about care because it mattered for the patient. During interviews preceptors would say, "I still have to remind him about the importance of turning the patient and suctioning if he needs suctioning" and "Don't you think we should check his [patient's] vital signs again because we just increased his Captopril?" According to an orientee, reminding was done "just real subtly, [the preceptor will] just say ... 'Well, does he, he has some labs he needs drawn?' She'll just point it out to me. She won't say, 'Did you check his labs' or something like that ..."

In relation to reminding, orientees quickly learned to read their preceptors body language. This was illustrated by an orientee during a first week interview.

> Orientee: She [the preceptor] gets on to me when I need it. When it comes to the turning and the importance of the [deep] breathing, you have to be a little more stern with me because I'm not familiarized with that yet. She knows when to step on the pedal.
>
> Interviewer: How does she do that?
>
> Orientee: Her voice changes, the tone changes, the look on her face changes. It's more of an urgent type of thing rather than get to it when you can ... When it's important and it needs to be done right then, that's when I know. She lets you do your own thing, but when she gets onto you about something, it's real important. I've come to learn that just in the past five or six days.
>
> Interviewer: So when you say she's gets on to you, what you're saying really is that she ...
>
> Orientee: She's trying to stress something to me. Instead of saying you need to do this, it's the patient needs to have this done. When I hear "the patient needs," I figure I'd better get on my horse. She really shows a lot of caring and tries to do what's best for the patient at all times...

The above example illustrates how the preceptor accomplished two learning lessons. She reminded the orientee about care that needed to be done,

and she simultaneously taught why this aspect of care should not be forgotten within the environment. Turning and deep breathing were good for the patient and if overlooked might result in harm to the patient. By reflecting on the message, the orientee realized that caring for patients came from caring about patients. Care delivered by nurses for the best interest of patients is the foundation for the practice of nursing.

In this situation the orientee also learned about salience. Some aspects of care could be delayed or overlooked without consequence, while others were so important they could not be overlooked. The message was conveyed without talking about but by implying importance. The preceptors' non verbal message conveyed that turning and deep breathing were so important to the patient's well being, they demanded the attention of the nurse. However, by focusing on the patient as the one who mattered, the orientee was not offended by the reminder but rather impressed by the caring stance of the preceptor. The orientee understood that if the experienced preceptor felt it mattered that much for the patient, it must be very important.

Thus, the preceptor was putting into perspective what was already known. Nurses learn about coughing and deep breathing in school, however, putting their knowledge into the perspective of practice takes place in individual work settings. By interpreting the environment, the preceptor was able to make the orientee understand what was expected of her (Daloz, 1992).

While reminding had the potential to be viewed as negative feedback, interviews with orientees indicated that it was viewed as helpful. As an orientee explained,

> She just helped me realize that there were some things that I needed to do .... She just reminded me. It was stuff that I would have overlooked and I wouldn't have went back to see if I did it or not because I was so caught up in what I was doing at the time, so she's helped me in that way so I wouldn't miss any medications or labs ...

In the example the orientee viewed the preceptor as someone who could remind the orientee because she was there to help. Reminding kept the orientee out of trouble and safeguarded both her and the patient from acts of omission. The orientee recognized that she was on a journey of development and on the journey she "got caught up " and lost sight of all that needed to be done. Therefore, she viewed the reminding as a positive and necessary movement into her practice at the point in time.

Both of the above examples demonstrate the trusting relationship the orientee had with the preceptor. Trust is an element that is essential to the success of learning partnerships and relationships (Daloz & Edelson, 1992; Lovin, 1992). Trust in learning relationships "encompasses the right to critique and be critiqued, to question and be questioned, and to disagree" (Lovin, 1992, p. 65). When trust is present, these rights become techniques that promote learning. Thus reminding was viewed as a teaching practice that was used to help and safeguard the orientee and patient during a difficult learning phase.

Rescuing

In some instances preceptors moved into situations to come to the rescue of the patient, the orientee, or both. Coming to the rescue meant that the preceptor moved in and took over a situation. Moving in to rescue was deemed necessary for a variety of reasons including the inability of the orientee to handle a situation or to prevent acts of omission or commission. The need to rescue demonstrated how important it was for preceptors to monitor and check on orientees. By being watchful and checking on orientees, preceptors were able to detect and move quickly into situations. Because preceptors were readily available, risks could be taken and orientees could observe or stay in and experience situations they were not yet ready to handle alone. Safeguarding by

coming to the rescue provided a secure environment for orientees to learn about high risk situations that were commonplace within the work settings.

Coming to the rescue of a patient and orientee was described by a preceptor during a third week interview.

> One patient she did the discharge and that was one of those where she'd already done about six and ... I let her do it on her own, and it was the first one I let her do on her own, and she discharged the patient and the patient left. It was like Sunday morning and I went back and I picked up the paperwork to just check it and see like what she wrote for a continuing plan or something that the patient might need, and there were no dates on it. And the doctor hadn't signed the discharge summary and it was blank. And so I ended up, she wasn't even there [on the unit] and I ended up running downstairs to the discharge clerk and get the patient and the paperwork and bring it back up. And I kind of learned that I needed to follow her closer.

The above instance was a learning experience for both the orientee and the preceptor. When she returned to the unit, the orientee learned what she had missed in discharging a patient. The preceptor learned about the boundaries of a new nurses' practice, including the limits of the orientee's practical knowledge at that point in time. The situation illustrated that trust between the teacher and learner in relation to the ability to perform activities was not reciprocal and would only be established after it had been tried, tested, and proven.

In the example, the preceptor came to the rescue of the orientee and the patient. The orientee was rescued from violating procedures of the system and the patient was rescued from an improper discharge without written instructions and orders. Both were protected from error. By coming to the rescue of the orientee and patient, the preceptor exercised her role of safeguarding and validated that checking on and rescuing were necessary teaching practices at this phase in learning. These practices as a part of teaching/learning process demonstrate that teaching in the hospital setting is much more than a transfer of knowledge. In many situations getting it right is a result of the experience of

getting it wrong. However, if getting it wrong is not revealed to and reflected on by the learner, the lesson from the experience may not be learned. Also, if getting it wrong is potentially harmful, then the innocent must be protected. Therefore, safeguarding becomes a significance role of the preceptor.

Another example of rescuing was described by a preceptor during a fourth week interview. In this situation, an unstable patient was transferred into the ICU without an IV infusing and without physicians orders.

> Preceptor: We had a patient come up who didn't have any [doctors] orders. The patient we got from the ward, the guy has a low blood pressure. He has a heplock going and there's no orders. We get another blood pressure. [I ask] Is this acceptable? This is not acceptable.
>
> Interviewer: Did she [the orientee] recognize that?
>
> Preceptor: She didn't say anything. But when I started talking about it. This is not okay. We need something for him now. Then I act. [I say to the doctor] Do you want fluids? Do you want Dopamine? What are we going to do?
>
> Interviewer: So you took over in that case.
>
> Preceptor: Yeah. It takes time. It's going to take time. His blood pressure dropped 20 points in two minutes. This is a bad omen.
>
> Interviewer: Did she notice that?
>
> Preceptor: No, she was focusing on getting the dopamine set up. I was trying to anticipate what was going to happen.

Even in fourth week interviews, orientees had difficulty handling rapidly changing situations. Such events require an immediate grasp of the situation, knowledge of what needs to be done, and an ability to intervene and implement appropriate measures (Benner, 1984). Realizing the severity of the patient's condition and the orientee's inexperience in handling such situations, the preceptor moved in and took over. She did not exclude the orientee from assisting but she took command. Her decision was based on what was best for a patient who was losing his blood pressure and needed immediate treatment.

During the process of taking over, the preceptor gave the orientee the opportunity to see her in action and to hear what she was thinking and saying. Whether that translated into learning could not be interpreted. What could be interpreted was the responsibility the preceptor assumed to move into the situation and safeguard the patient. Without rescuing the patient, the severity of his condition may have gone unrecognized and treatment delayed.

Safeguarding could be debated as a teaching role. In this situation, the question could be asked as to whether the preceptor relinquished the role of teacher to become the primary caregiver. However, if the role of teacher is to provide a safe environment for learning, then she did not relinquish the teaching role. Rather, she acted in the best interest of both the patient and the orientee by advocating and safeguarding both.

Both situations demonstrated the flexibility precepting required. Preceptors moved in and out of situations with only a moment's notice carrying the responsibility for the well being of both patients and orientees. The roles of nurse and teacher were equally important and involved making judgments about what was good and appropriate for both the patient they nursed and the orientee they taught. Such practice requires an ongoing process of interpretative thinking and acting in order to respond responsibly to those we are accountable for (van Maanen, 1991). Thus, coming to the rescue of patients and/or orientees can be interpreted as responsible practice in situations where others are not able to assume a level of responsibility.

The reaction of orientees to rescuing was varied. In some situations, they were so overwhelmed and unfamiliar with what needed to be done, they stepped back to observe and let the preceptor take over completely. In other situations, orientees stayed in a situation and did what they could but looked to their preceptor or other more experienced nurses to handle major elements of care.

These responses correspond to the findings of other researchers who have determined that inexperienced nurses are detached from situations and often stand outside as an observer (Benner, Tanner, & Chelsa, 1992).

The following two examples illustrate both levels of response. The first example was from a fourth week interview where an orientee related an experience with a patient who was about to be discharged but developed a low blood pressure and became dizzy.

> I was totally useless in that situation. I was doing his discharge. He was in his street clothes ready to walk out. He sat up on the bed and said, "I'm dizzy." I took his blood pressure and it was incredibly low. I said, "Don't stand up." I remember him telling me earlier that he was getting more of the heart med than he takes at home. He lay down and I went and got [the preceptor] .... We checked it [blood pressure] again and it was worse. [The preceptor] went and got the doctor .... I'd pulled his IV out .... I can't start an IV. I'm not good at all. I was useless. I stood back and watched and ran a couple of errands. It was fascinating and next time, I'll know.

Once the severity of the described situation was realized, the preceptor moved in to rescue and the orientee moved out to become an observer. Prior to the fast action of the situation, the orientee acted appropriately. She took the patient's blood pressure in response to the complaint of dizziness, she suggested the patient not stand up with a low blood pressure, she immediately got the preceptor, and she recognized that his medication might be a cause of the drop in blood pressure. However, she was not able to keep up with the fast pace of a situation which required skills and knowledge she had not yet acquired. Because she was rescued and able to stand back, she did learn. She felt so safe in her detached stance that she was fascinated by occurrences and came to realize what would be needed in another similar instance. No words were spoken between the preceptor and orientee about replacing each other. The actions were instinctive and in response to the needs of the patient in relation to the capability of the nurse.

In the second example, the orientee stayed in the situation and did what she could but looked to others to take over the more advanced aspects of care. The example was described in a third week interview and involved dealing with the family of a patient who died.

> Orientee: His [patient's] wife came to the nurses station and says, "He's not breathing at all." [The preceptor] went in there. [She said], "Get a manual blood pressure cuff." I went in there. I hadn't taken a manual blood pressure in five months and that was somebody with a blood pressure. And my hand was shaking. I felt like I was just pretending. By this time the family was in the room. I could hear his daughter say, "What did they do to him?" I thought, she thinks we killed him doing AM care or something. Maybe it looked that way because we had just finished.
>
> Interviewer: How did people respond to that?
>
> Orientee: I was able to blow it off because I was taking his blood pressure. Whenever I got through, I looked at the doctor and he said, "Nothing?" and I said, "No." The daughter was still [saying], "What happened? What did they do?" I just sort of looked at her and [another nurses said], "He died ... He was very, very sick. He was getting worse and it just happened." And I'm thinking, I hope [the other nurse] can keep talking through this one. Then the wife said, "He was getting worse ..." So the wife had come to terms with it. But this one daughter seemed like she wanted to point the finger. [The preceptor] told me later that that's a common reaction.

The example depicts an orientee doing what she could during an event that required understanding and communication skills beyond her knowledge and skill level. She looked to her preceptor and the other experienced nurse for help with the daughter's reaction and got her wish. The experienced nurses understood the daughter's remarks as a normal reaction to death and were able to handle them as such. They did not take the remarks personally but rather placed them within the context of the situation. They were able to do this because they had been there before and witnessed similar events. The experienced nurses took over and saved the orientee from having to deal with an event she did not fully understand nor know how to deal with at her stage in learning.

Summary of Safeguarding the Patient and Orientee

The hospital environment poses potential risks for very ill patients being cared for by inexperienced nurses. Preceptors are responsible for the well being of both patients under their care and orientees assigned to them. This study demonstrated that safeguarding was a practice utilized by preceptors to protect patients and orientees in the high-risk hospital environment. Safeguarding involved considering and ascertaining what level of supervision or assistance was right at any one point in time and, as a result, deciding when to move in and out of situations, to intervene, or to allow independence in practice.

Preceptors utilized several considerations to determine whether to move in and out of events. These considerations included the stability or instability of a patient's condition, available time, where orientees were in the learning process, and how well orientees remembered what care to provide patients. Preceptors moved into situations when patients were less stable and more acutely ill, when time was limited, when orientees were at a point in the learning process where they were unable to handle an event, and when they overlooked aspects of patient care. They moved out of situations to foster confidence and independence when they considered situations safe for patients and orientees. Preceptors gauged the timing for moving in and out by being aware of the environment including what orientees were doing and how they were handling events.

When preceptors deemed situations actually or potentially not right or safe they moved in to check on, remind, or, at times, rescue. Checking on meant following behind orientees to ascertain that scheduled and unscheduled work was completed. Checking on was done openly and honestly and in the interest of the patient. Therefore, checking on was welcomed and perceived as helpful by orientees who realized that during the learning process, they needed backup

and a safety net to protect them from the harm of not remembering elements of care.

A natural follow up to checking on is reminding. Reminding not only prevented errors of omission, but also taught about salience. Orientees learned what elements could safely be omitted or delayed and which elements were so important they could not. Orientees learned this lesson by listening to what their preceptors said and by interpreting their non-verbal communication. Preceptors again reminded in the best interest of the patient and, therefore, engendered the trust and gratitude of the orientee.

The final safeguarding practice revealed in this study was that of moving in to rescue. Preceptors came to the rescue of patients and/or orientees by moving in and taking over situations the orientee was not yet fully capable of handling. By rescuing, preceptors restored safety and ensured that appropriate actions were taken. Orientees realized the necessity of rescuing, knowing that their inexperience prevented them from being able to handle high risk, unfamiliar situations. Therefore, they were grateful for the assistance or taking over by the preceptor.

Balancing the Demands of Caregiver with Teacher

During this study, preceptor participants had responsibility not only to teach orientees but to care for patients and in some situations to function as charge nurses. Dual roles were necessary to provide a learning environment where practical knowledge could be obtained and to meet organizational demands with allocated resources. Meeting the obligation of patient care provider and teacher required organization, flexibility, ingenuity, a sense of salience about where to focus attention at any one point in time, and support from others. The preceding chapter described practices preceptors incorporated in order to simultaneously teach and care for patients. These practices

demonstrated how preceptors used the patients' bedside and surrounding environment as the learning laboratory with the patient as the focal point of learning (Figure 12).

Figure 12. Balancing the Roles of Teaching and Caring for Patients.

Utilizing such practices was appropriate since practical knowledge was the desired outcome and could only be acquired in the real work environment. While the risk of learning in such situations is high, particularly in hospitals, it has been shown that the practice of safeguarding was utilized to ensure safety for patients and learners. Since teaching practices have been discussed, this section will describe how preceptors described being able to deal and cope with dual roles and the assistance they obtained from others to create a favorable learning environment.

Attributes Contributing to Dual Role Success

Even though being responsible for both patients and orientees increased the workload of preceptors, they described dealing with the dual role in a satisfactory manner and in fact, were gratified by the experience. As a preceptor explained, "It's gratifying to me to feel that like I'm contributing to this person's learning, to their career." Preceptors attributed their ability to handle both roles by being organized, experienced, flexible, and able to spend time with their orientees. These abilities were described by a preceptor in response to a question about how she was able to handle the dual role.

> It hasn't been a problem for me ... she's so easy to work with. Once I have everything organized and I know what time frame I want things done in, if it starts to fall off that schedule, I know how to redo things. My main thing is organization. When I know what's ahead of me I start planning. Because I have such a long ride coming to work, I'm kind of planning things through my mind as I'm coming to work as far as my day .... Once the day starts, if it's not staying on schedule, I may regroup.

This example illustrated how the preceptor planned her day by getting mentally organized before she got to work. Even thought her day was planned, the potential for disruptions was realized and was not cause for concern. The preceptor's confidence in her ability to be flexible, to "redo things" and "regroup" were indicative of her experience (Benner, Tanner, & Chelsa, 1992). Experienced nurses have confidence in their ability to organize and prioritize because they have a sense of salience about what aspects of work to take care of and what may be left out, if necessary. Thus, the ability to organize and prioritize enabled experienced preceptors to fulfill dual roles and to direct and shift their attention to both patients and orientees.

This finding lends insight to the concern raised earlier about whether experienced preceptors are the best teachers for inexperienced nurses (Benner, 1984). This study indicated that patient care was central to learning how to practice nursing. Therefore, having a patient care assignment was necessary to

provide a training ground for learning. To fulfill these roles, preceptors needed to be organized and able to make good judgments, based on a sense of salience, about where to direct attention. Since these abilities are developed by working with similar patient populations over time (Benner, 1984), experience in the designated orientation environment may be a condition for precepting. Data from this study also showed that when preceptors had organizational skills and were able to establish priorities based on a sense of salience, they were able to be flexible and handle both roles to their satisfaction.

The effectiveness of preceptors and difficulty in performing dual roles was recognized by orientees. Throughout interviewing, orientees paid unsolicited compliments to their preceptors and recognized the difficulty that the dual role presented. As an orientee explained,

> I hear people say, "Oh, those people that precept students [orientees] are lucky, they just stand around with a cup of coffee and make the students do all the work." No, they have to do every little thing and explain everything and they can't ... just buzz by anything out of habit as if the darn student wasn't there. It's a lot of work taking a student on.

The comment demonstrated insight into the dual role. An experienced nurse can provide care to assigned patients quickly and efficiently, performing many duties out of habit and by utilizing learned shortcuts. When responsibility for precepting is added, every act must be explained and role modeled according to the book with attention to detail. As a preceptor remarked, "I wouldn't want to give her wrong information. That would be scary for me." Thus for experienced nurses, teaching about patient care was far more time consuming than simply doing it themselves. Added to the increased time it took to teach and do work, was the energy required to provide orienting nurses with support, assistance, monitoring, and evaluation through the difficult transitional period.

Another reason that preceptors were able to successfully accomplish dual roles, was because they functioned as responsible agents and advocates for

both patients and orientees. This representative stance was expressed by a preceptor as "I'm responsible for these patients. And I'm responsible for [the orientee]. I would be devastated if not only a patient had a bad experience, but [the orientee] did along with it." Because teaching and learning revolved around the patient and learners were performing new skills, risk was high. Therefore, the commitment to responsibility had to be taken seriously and was necessary to successfully and safely perform the dual role. Preceptors accomplished the dual responsibility by connecting with orientees and patients so that both were cared for; cared for both in the sense of being sensitive to feelings and in the sense of having the knowledge and skill to provide for physical and cognitive needs. Preceptors functioned as caring agents who met the needs of their patients for their benefit but also in the interest of teaching orientees how to practice nursing. They did so in a way that caused orientees to remark, "She's a good nurse", "She really shows a lot of caring and tries to do what's best for the patient at all times" and [my preceptor's] a teacher, mentor ... a support system ... She's a friend."

Caring for and about patients and orientees was not explained during interviews but rather inferred. In this sense caring was embodied in the practice of preceptors. Preceptors in this study had many years of experience in their assigned areas and described knowing how to take care of the majority of patients they encountered day by day. By reflecting on past experiences, teachers gain an awareness of "everyday actions and experiences" that provides a foundation for teaching others (van Maanen, 1991, p. 209). Thus thoughtful reflection transformed embodied knowledge and skill about how to care for patients into a form that comprised the practice of precepting. Without knowing how to be agents for patients, preceptors would not know how to be teachers who taught orients how to care for patients. Our own thoughts and actions can

only be made known to others when we understand how they dwell within ourselves (Polanyi, 1965).

Being able to spend time with orientees was also a factor that contributed to successful handle dual roles. The importance of this was revealed by the expressed frustration that accompanied lack of time with orientees. This major source of frustration was described in situations where patient care demands were high and in the absence of other staff, preceptors were assigned additional responsibilities which pulled them away from their orientees. As a preceptor explained, "I couldn't do everything that I needed to do. I couldn't be a good preceptor because I wasn't there. I was too busy taking care of other patients, other problems .... Short staff. That was the problem." To counteract this difficulty, in the early phase of orientation, preceptors would assign orientees study time or to be with other staff, or would "kick into another mode and say, 'just watch me." Later in the orientation period, they had "to be trusting that she [orientee] would come get me." Preceptors felt "sorry for [my orientee]" and realized that for orientees, "it can be frustrating ... and she [orientee] seems kind of lost when I'm not around." Not being there for orientees was a source of stress for preceptors and caused them to lower ratings of themselves. These feelings were situational and were rectified as workload allowed them to spend, what they considered adequate time, with orientees.

The Role of the Environment in Dual Roles

While this study has focused on the teacher and learner, interviews and pictures revealed that preceptors and orientees did not function in isolation. They were members of a health care team all of whom interacted within a unit environment. The quality of an environment is critical to how learners develop. Teachers are only one part of the environment that shapes development (Daloz,

1986) and because preceptors were required to fulfill dual roles, they depended on others to assist with teaching in their absence.

In this study, orienting to the new environment was facilitated by team collaboration and many members contributed to the learning of orientees. The contribution of the team was described by an orientee as, "the nurses are always really good about grabbing me to do new things, show me new things, explain new things, answer my questions." The explanation illustrated how people, other than the preceptor, realized the needs of orientees and took it upon themselves to contribute to their learning. Throughout interviews, orientees described how staff went out of their way to seize opportunities to expose them to new situations. Not only did these actions enhance knowledge base, they also had meaning in terms of transition. Orientees described learning in an environment where interactions were directed toward their development and staff went out of their way to assist them to learn and adapt.

Preceptors promoted the concept of team by relaying messages to orientees such as, "I reinforce to her that she's never going to be alone out there. There's always going to be a resource person. Everybody has a resource person. That's the only way we're going to make it." Such messages prepared the orientee for times when the preceptor was not readily available and distributed responsibility for teaching. According to orientees, the message was reality.

> I just never feel stupid asking a question, it doesn't matter who is walking by, I go ..." Where do they keep the such and so..., where is there a flow sheet for this?" ... Everybody's just great, it's like having a whole floor full of preceptors.

The described transaction between the orientee and the environment created an experience which encouraged inquiry, made the orientee feel comfortable in not knowing, and made information available. By feeling

comfortable in seeking information, orientees were more likely to seek out answers to questions rather than learning by trial and error and preceptors could feel more secure when they were not available knowing that team members were willing to respond.

Summary of Balancing the Demands of Caregiver with Preceptor

In most instances in this study, experienced preceptors were able to meet the demands of the dual roles of patient care provider and teacher without difficulty and with gratification in knowing they contributed to the development of orientees. Interview data revealed meeting these demands was possible because preceptors were organized, had a sense of salience about how to prioritize, were committed to patients and orientees, and were skilled in caring for patients within their unit populations.

Qualities that enabled preceptors to function in dual roles included organization skills and having a sense of salience. With these qualities, preceptors were able to plan how they could best serve in the dual roles, yet be able to deviate from their plan should unexpected events occur. Their experience in both areas enabled them make decisions about what was important and what could be omitted. An embodied commitment to patients and orientees positioned preceptors as responsible agents and advocates for both. This commitment combined with knowledge and skill in caring for patients provided the means for preceptors to transform their practice of nursing into a foundation for teaching. Functioning in dual roles produced frustration when preceptors were not able to give orientees and/or patients the attention they felt they needed.

The final factor revealed in this study that contributed to functioning in a dual role was support from other members of the health care team. This support and assistance created a positive learning environment that enabled orientees to

seek assistance from everyone without intimidation. Preceptors promoted the concept of team by encouraging orientees to use others as a resource. Orientees tested the concept with success and felt comfortable going to others. As a result, orientees could comfortably seek help in the absence of the preceptor without having to learn by trial and error.

CHAPTER VII
THE JOURNEY TO INDEPENDENCE

Two patterns and associated themes identified from analysis of interview data that facilitated the journey to independence will be described in this chapter: (a) launching the orientee and (b) the journey to independence: advice from beginning to end. The journey to independence represented the interactive process that preceptors facilitated to reach the desired outcome of safe and autonomous practice for orientees. At the end of the orientation period preceptors expected orientees to act and think differently, to know about available backup and support, and to realize that gaining practical knowledge was an ongoing process that began during orientation. By incorporating the teaching domains of precepting with the tact of precepting, preceptors guided orientees to independence. To help them arrive as quickly and ably as possible, they incorporated concernful launching practices which assisted orientees on the journey. Launching practices were entwined with other precepting practices and were intended to move the orientee from dependence to independence. This movement toward independence was facilitated by the preceptor but was a dynamic process that involved both the teacher and learner.

The Launching Process

The goal of the practice of precepting was to move the orientee from an observer and outsider to a doer and insider and from a state of dependence to independence. Studies have demonstrated that inexperienced nurses function as detached observers who stand outside of unfamiliar situations (Benner, Tanner & Chelsa, 1992). This is particularly true in nursing where, as described

in previous chapters, many situations that orientees confronted were scary and caused them to be hesitant in assuming responsibility. As nurses gain experience they involve and engage themselves and gradually gain the confidence and ability to assume responsibility for situations. Realizing this and in order to promote independence, preceptors described practices which promoted involvement and supported discovery and learning. The practices included providing support and assistance, acting as a resource by answering their many questions, and sometimes when necessary, urging and pushing orientees to engage themselves.

Readiness to Launch

A part of the process of launching was recognizing when orientees were ready to assume responsibility. This was determined by watching and listening for verbal and non verbal expressions of comfort/discomfort, number and types of questions asked, and the amount of exposure the orientee had to a situation. Preceptors related, "She is really good about 'what do you think of this? I have a question about this." or "... she hasn't had much experience with those guys yet ... It will take a few more." Preceptors were patient in waiting for readiness as illustrated, "In the past if I had picked up any kind of ambivalence on her behalf, I would say, okay ... I'll do it this time, but what I want you to remember when it comes your turn ...

Readiness also may have been situational and involved waiting for a good time to learn; a time when the preceptor had time to spend with the orientee. As a preceptor related,

> We got a bunch of admissions at the end [of the shift] and I was like whipping them [doctors orders] off and I just kind of let her watch for 15 minutes ... but then the next day we got one earlier in the day with lots of orders so that was good because we had time and we sat there with all those orders and we went through them all, slowly, but surely but with me saying, ...' you've got to sign here, now you're done with this one, now go on the next ...'

The approach of waiting until the time was right was recognized by orientees. They related, "She's told me she wants to take it slow and not push me into anything." and "people are getting chest pain all the time and that's a scary thing. I've been with (preceptor) a couple times, but she takes over." Waiting until orientees were ready to assume responsibility showed concern for the orientee, promoted trust, eliminated barriers to learning such as impatience and going too fast, and thus, made the experience humanistic and favorable to learning.

Preceptors, however, did not wait indefinitely for orientees to engage in situations. When they felt the time was right and, if necessary, they would urge orientees into situations. The urging was described as "pushing," "prompting," and "nudging." However, when the orientee was urged into an unfamiliar situation, she was accompanied and supported by the preceptor as described,

> I said, "You do them [doctors orders]" ... And she said, "Well, I'll get lost." I said, "No, you can do this, because this is where we're beginning. And I will watch you. I'll stand by your side and I won't let you do it wrong."

Support during Launching

Providing support for orientees during launching took on many dimensions. Verbal support provided encouragement and reassurance and filled in knowledge gaps. The physical presence of the preceptor offered security, safety, and sometimes the challenge of not doing anything but observing (Figure 13).

Verbal support and physical presencing were usually provided together as illustrated by a preceptor who described how she launched an orientee in discharging a patient.

> I just stood by. I would interject if I thought she had really forgotten something or I would wait and see if she was going to forget it or not. And if she did, I would interject and ... she has done a lot of them now.

Orientees described launching as,

And then she had me do the entire thing and she stood there and I would just do as much as I knew was right and I would get stuck and say, should I be, am I supposed to ... [and she would be] reminding me, now be sure to check over here too ...

Figure 13. Providing Physical Support during Learning.

Support in the form of encouragement and reassurance was conveyed as, "Yes, that's correct, you're doing it correct" and "(you're) doing fine, don't worry about it." These messages affirmed that orientees were dealing with situations correctly and gave permission to proceed. The knowledge and skill of preceptors functioned as a standard against which orientees could measure their performance. If orientees "weren't quite sure" or "forgot something", preceptors would "stand next to" or "behind" them and "tell", "remind", "point it out", "interject every now and then" or "correct me (orientee) if I'm doing it wrong." The approach of filling in the knowledge gaps in these real life situations was necessary to ensure that the inexperienced orientee's practice was safe and correct and to assure a favorable outcome for the patient. Filling in the

knowledge gaps continued until the orientee could handle a situation at a level that met the preceptor's standard. This was expressed as, "I felt comfortable that she could do it." In addition, preceptors gauged successful learning in terms of the orientee's expression of confidence, "... she tries to make sure I know what I'm doing and then, she'll ask me, 'Do you feel comfortable with it?"

Support also came in the form of not doing by standing back and watching. Standing back and watching occurred at the end of the learning continuum when the orientee knew enough to handle a situation, but for whatever reason, the preceptor felt that some level of supervision was needed. As a preceptor explained, "I just stood back and watched her, which is hard for me to do with a new graduate...to step back and keep my hands off and my mouth closed most of the time." Support in the form of not doing was timed to occur at a point where orientees had demonstrated capability and the preceptor felt they were ready to be launched in a particular situation. Such an instance was described by a preceptor who was overseeing an orientee start an IV on a patient.

> With another IV start today and she put the tourniquet on the man, I was with her but I didn't do it. I didn't hand her the tubing...and this and that and so I just watched her and she did fine .... she explained to the patient what she was going to do .... She asked me to come over and asked what I thought of this vein and I said, "You go for it" and it just so happens that I got a phone call and I said, "I'll be right back." But I purposely did not go back right away and I gave her time to. I was right at the nurses station and this patient's room is just two doors down ... so I could hear any cries for help ... but I purposely gave her a good five minutes and when I went back in she was taping it down and she was very pleased with herself.

The example showed how, by staying away, the preceptor supported the orientee by demonstrating confidence in her ability to independently start an IV. The timing of her presence and absence was thoughtful and showed concern for the patient and orientee. The preceptor stayed long enough to see that the orientee was carrying out the procedure safely and correctly and then left at the

crucial moment of putting the needle in the vein. Even when she was present, the preceptor hung back, indicating that she was there only to support and not to assist unless necessary. Her distancing strategy worked and the orientee was able to accomplish the procedure independently and be pleased with herself.

In some situations this period of learning can be sensitive as learners find out what they know versus what they don't know and are comparing themselves with others (Gremmo & Abe, 1993). However, in this study, orientees found the verbal and physical presence of the preceptor comforting and helpful and related, "she's always right there in case I get lost or forget to bring supplies or something ..." Orientees did not view the constant one to one observation of the preceptor as oversight but rather as assistance in helping them meet their goals as described by an orientee.

> The day before, she showed me how to do it. So I'm doing it and she's assisting, but she's watching over to make sure I'm doing it the right way. I think it's worked out really good, just working together. Someone showing me how to do it and do it over again, and she'll correct me if I'm doing it wrong. It's one to one teaching ... she really showed me one to one.

Another supporting role that preceptors engaged in during launching was acting as a resource (Figure 14). This was accomplished by listening and responding to the many questions presented by orientees as they learned to handle complex situations.

An orientee related, "I would ask the poor woman a thousand questions..." Preceptors listened for questions and viewed inquiry positively as a mechanism for acquiring learning because, "... she asks a lot of questions. She'll keep asking until she is satisfied and comfortable ..." They also viewed inquiry as an indicator of safety and said, "I get real nervous when I don't hear questions." The importance placed on inquiry was explained by a preceptor,

> She's [the orientee] very conscientious, she cares about what she does. When she doesn't know she seeks the answers out. She finds her

resource person. She doesn't forget. If she can't do it, she'll tell you. That's important. We make our biggest mistakes when we think we know it all ...

Figure 14. Responding to an Orientees' Questions.

Preceptors reported experiences with orientees who did not ask questions and as a result stated, "You have to watch them even closer...If they're going to ask you questions, I feel much better than those who don't."

Orientees viewed availability for questions as, "being there for support." An orientee explained, "If I have a question, she doesn't just leave me there. She comes back and says, 'did you get it done? Did you have any problem?" This example illustrates that acting as a resource involved not only responding to questions generated by orientees but actively seeking out questions. As an orientee explained, "She asks me frequently, 'do you have any questions?"

Assisting to Regain Control

Various stages of learning have different requirements. Learning to become independent in practice required assistance along the way. Assisting with work was necessary and effective as orientees became more independent in their practice because it preserved the orientee's space. Preserving a person's space enables them to regain and maintain control of a situation (van Maanen, 1991) so that they can carry on independently. Such launching actions were reported by a preceptor during a fourth week interview and by an orientee during a second week interview.

> Preceptor: I think I just show up. I kind of lend an ear or hand. Sometimes I come along and help her get out of a spot, but I don't notice [what] I've done. Maybe I've made some beds while she's doing something else. I don't know how that's helping that much.

> Orientee: She was sitting back and letting me do it on my own. I don't remember anything coming up I couldn't handle. She let me set up because I wanted to do it, it helps me learn. She looked over what I had set up and when the patient came back from the OR he was stable. She let me do that Art line and assisted me with things I needed help on. Once the patient came out, she took over the other guy and I stayed with the post-op patient.

Both of the above situations illustrate the tacit dimensions of preceptors practice in terms of assisting. Neither teacher nor learner realized the meaning or impact of the preceptors actions on learning. In the first example, the preceptor described assisting the orientee with a simple task, making beds; a task the orientee would have been very familiar with. Yet the small act of moving in to make beds kept the orientee on schedule and allowed her to continue moving forward with her plan for the day. The assistance was timed to occur after the orientee had an opportunity to handle as much as she could, and to keep her from becoming frustrated and anxious from being behind. While the preceptor's action could be viewed as minimal, it was indeed a part of helping the

orientee contend with the effects of being new and maintaining a sense of control, thus preserving her space (Figure 15).

In the second example, the assistance the preceptor rendered was also tacit. Even though the orientee described the preceptor's assistance, her perspective was that she had handled the situation. Although the orientee talked about the preceptor checking on the set-up, assisting with the arterial line, and taking over care of another patient to allow the orientee to concentrate on the new admission, she seemed oblivious of the impact. The description indicated that the actions of the preceptor were enacted in such an unobtrusive manner, that the orientee was unaware of the role they played in helping her handle the situation without error. As a result, the orientee described confidence in her role and ability to admit and care for the patient.

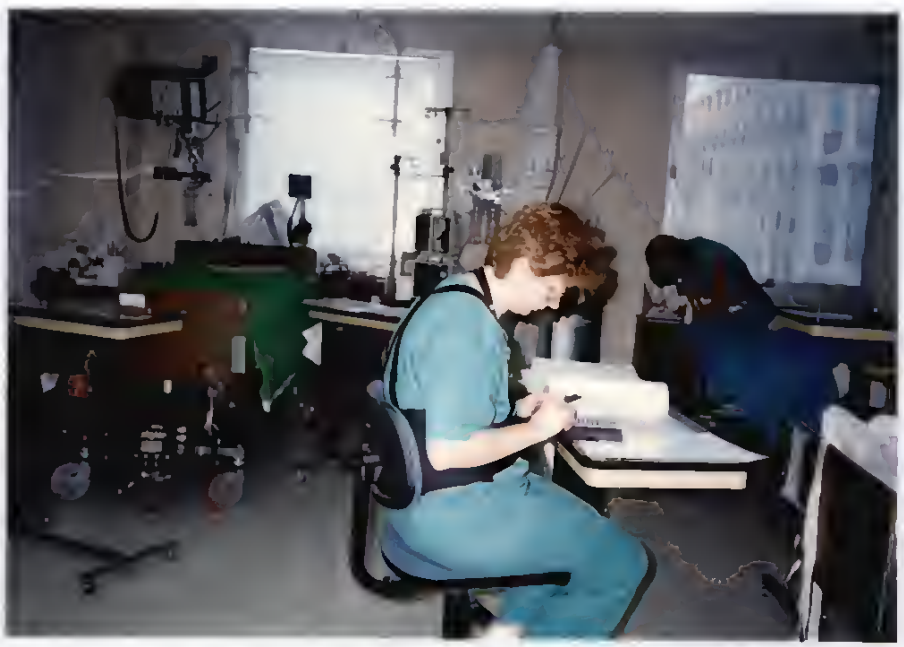

Figure 15. Preceptor in Background Assisting the Orientee.

Both situations illustrated the adept timing of the assistance in the learning process. The timing was such that the assistance was barely noticed by the teacher or learner, yet provided what was needed at the moment in time and learning. As a result of the assistance, orientees were able to focus on learning and move toward independence without the frustration of being behind and with confidence in their capabiity.

In other situations, assistance by the preceptor was apparent and welcomed by the orientee as described during a fourth week interview.

> Well you see, I try to do as much as I can daily ... if we had two patients, I try to do what I can do for two patients. And then [the preceptor] will come over there and start taking care of one of them and doing some stuff to the other one, but basically I try to do my physical assessments and the charting on both guys, plus their meds. And then its something where if they get messed up somewhere along the line, [the preceptor's] there to oversee and make sure that I don't die. Make sure that I don't end up in an ICU bed myself. So it's the way she's precepting me. I'm sure [the head nurse] had that in mind when they interviewed me and told me that [name of preceptor] would be like the best preceptor for me.

This example illustrated how assistance and challenge were offered simultaneously. The orientee described assuming responsibility for an assignment she could not quite handle at this point in the learning process. The assignment, however, challenged the orientee to learn to organize and complete care for two acutely ill patients. The challenge created tension for the orientee, and if not for the assistance of the preceptor, risk for the patient. The preceptor was able to expand the orientee's capability boundaries in the launching effort and still safeguard the patient by challenging her to do as much as she could and only assisting when the orientee's limits were reached and care was yet to be given. Challenging in this situation required understanding of how much the orientee could do before getting too far behind and becoming frustrated, both of which could be threatening to the patient. The orientee was aware of the need for assistance at this time, yet was also aware that the challenge of today was

the reality of tomorrow. Thus, the assistance and challenge were both necessary and desirable practices in the process of launching.

Summary of the Launching Process

The process of launching assisted orientees to move toward increased independence in their practice. Launching was entwined with the domains of teaching and the tact of precepting and was a facilitatory process enacted by the preceptor in collaboration with the orientee. The first step in the process was determining when orientees were ready to be launched. Determining readiness required sensitivity to comfort level, knowledge, and skill. At times, pushing and pulling were deemed necessary to prompt hesitant orientees into uncomfortable, scary situations. Once preceptors ascertained that orientees were ready to be launched, they would support the learning process, act as resources by answering the many questions that arose during the learning process, and assist orientees with their work.

Support meant providing verbal and physical support by filling in the knowledge and skill gaps, being present to observe and provide security, and when preceptors felt orientees were accurate and safe, not doing anything. The role of resource was accomplished by responding to the many questions that orientees had about their unfamiliar environment. The constant demand for answering questions required patience and a willingness to be interrupted at frequent intervals. Assisting orientees in their journey to independence was described as both an outward and tacit action. In many situations neither preceptors nor orientees were aware of the impact of the assistance they provided. However assistance was given, it was timed to give orientees ample opportunity to do as much as they could and to prevent them from losing control and becoming frustrated.

The Journey to Independence: Advice From Beginning to End.

Interview data from this study, revealed that precepting required actions and involvement that responded to the situation of being new and were directed to moving the orientee forward in the learning process toward independence. These types of action involve thoughtful reflection and are "always framed by the special orientation or commitment" that defines the relationship to others, in this study of the preceptor to the orientee (van Maanen, 1991, p.123). The nature of these actions that were perceived as being notable in assisting orientees on the journey to independence was identified by preceptors and orientees during interviews. Near the end of each interview, preceptors answered the question, "As preceptor you are assisting your orientee to make a role transition into a new clinical setting. If you were to share something important with another preceptor about how to facilitate the transition, what would it be?" and orientees answered the question, "As an orientee you are making a role transition into a new clinical setting. If you were to share something important with a preceptor about how to facilitate the transition, what would it be?" Responses to these questions will be summarized by week and are important to this study because they condense the role of the preceptor and reflect what they consider to be notable in their practice. The thoughtful and reflective advice is meaningful as representative of the previous week's lived experience. These articulated components of the preceptor's role demonstrated an intangible, tacit segment of their practice (Polanyi, 1962), yet one which was deeper and more comprehensive than the more tangible practices described earlier in the teaching and learning section. The week by week depiction lends insight into the journey to independence from beginning to end.

Week One: Coming to Know and Trust

Preceptor responses from first week interviews focused on trust, communication, and expectations. Preceptors expressed that during the initial phase of orientation, "there's a trust that you can develop with someone" to know that "they're not there by themselves" and that the preceptor "was there no matter what" and that the orientee could "always come to me, that you're not going to be thrown out there to kind of sink or swim ...." (Figure 16).

Being there for the orientee created a safety net that orientees could depend on to protect not only themselves, but the patient. Preceptors felt that "if she [the orientee] can learn to trust me, then she would feel good." Trust in the form of being there no matter what indicated that preceptors trusted themselves to be able to respond to orientees in "ever changing situations and environments" (van Maanen, 1991, p.158).

Figure 16. Week One: Getting to Know Each Other.

In relation to communication, preceptors verbalized that "being very communicative and keeping the lines open" was important. Preceptors specified that communication about "what they're expecting to do that day", that "reinforced theory knowledge", and that "kept [the orientee] abreast of what she's capable of...versus what I don't think she's perhaps not ready to do" was important. Communication assisted in developing "a good relationship, an open relationship." Open communication also involved "letting them know they can come to you and ask questions..."

Preceptors also expressed that in this initial phase of orientation, they "shouldn't put expectations too high and not assume anything." This meant that they had to "go slow and just make sure she feels comfortable ... before getting into something that would scare her off ..." Accomplishing this involved "utilizing the skills they have" rather than sending the message "you don't have any skills." Letting orientees know that "they have a lots of skills" and preceptors "have to help them incorporate them."

First week responses from orientees coincided with what preceptors said was important. Orientees suggested that preceptors "not assume how much I do and do not know" and "find out where I'm at." An orientee with some experience suggested that orientees "be treated like new graduates" and be brought "from the bottom up." Their advice was to "start from the basics and be able to quickly go over something ... and add to how much I know." Answers related to communication focused on "be patient and understanding and explain things" and "not to get aggravated over questions." One orientee found comfort in "she's ready to say, 'I don't know', but here's where we look it up."

Week Two: Supporting and Letting Do

Preceptor responses during second week interviews emphasized facilitation of learning by doing while providing support and repetition to enhance

retention. During this phase of orientation, preceptors felt it was important to "giving them the hands on and letting them do", while "keeping track in case she makes a mistake that could be dangerous for the patient." They advised it was important to "demonstrate well and allow them the time to redemonstrate" and "repeat things over and over again" (Figure 17).

Preceptors repeated emphasis on "try to make them feel comfortable and just not to overwhelm her ..." because "if someone isn't comfortable with doing something, they will shy away from doing it." Communication advice took the form of "tell them how far we'd gotten and what things she still needs to know."

Figure 17. Week Two: Letting the Orientee Do.

Advice from orientees during second week interviews reiterated the advice of preceptors. They advised, "I guess right now ... I learn a lot by hands on" and "just let me do it and stand over my shoulder..." At this phase, orientees felt preceptors should "find out how much they know and what areas have strength and weakness and work on that." Intertwined with the desire for learning by

doing was the advice of "just be patient" and "give support and encouragement" by being there and helping when they were "hesitating and wondering."

Week Three: Being Open and Available

By the third week preceptors were advising to "give a longer rope to allow them to do what they will" while still "being there for them" and "being there as a crutch as she needs it." These comments indicated that the presence of preceptors was still there, but was more distant to promote independence in practice (Figure 18).

Figure 18. Week Three. Encouraging Independence While Still Being Available.

The advice for support and communication continued in the form of "see how she feels about how the role has gone", remind them ... they're still new", and "give more positive feedback." At this point, preceptors were also advising that orientees begin to broaden their perspective of situations by "letting her know there's a lot of different ways to get to the same point." This also was a transition since initial teaching was usually done "by the book."

During third week interviews, orientees agreed with lengthening the rope and letting them "do things on their own." For simple things, they felt "it's not necessary to keep monitoring." However, they also wanted preceptors there "for a resource", to "keep an eye on me and remind me...", and "so if you feel like you're getting in over your head you can say, 'Come here." Orientees felt that this was a time for them to find out "what you know and what you don't." In this way, they also were fostering their independence by testing what it would be like after their orientation when they had to make decisions about when to do it alone or when to get help. During this phase, orientees articulated they would like preceptors to share "insight on their experiences." The request for sharing experiences related to "talking about the patient" and stories about "when she was a beginner." Sharing experiences indicated a desire for expansion of knowledge beyond that of simple tasks and to verify that what they were feeling was normal.

Week Four: Extending the Distance

Fourth week interviews with preceptors continued to emphasize independence and responsibility with preceptors increasing their distance from the learners. However, giving orientees "their own space and independence" was phrased within the context of "unless she hits an obstacle and is really not sure what to do." So while preceptors were "off in the distance, 10, 15 feet", they were "always watching" and listening and although they had lengthened their waiting period before moving into a situation, would do so if necessary (Figure 19).During this phase, preceptors also advised to let orientees know that although the orientation period was "nearing the end...we are aware that there are some things that you still don't feel comfortable about...and we will always be here for you." Preceptors had worked with orientees long enough to trust that if an orientee got in trouble, "she'll come to you when she needs it."

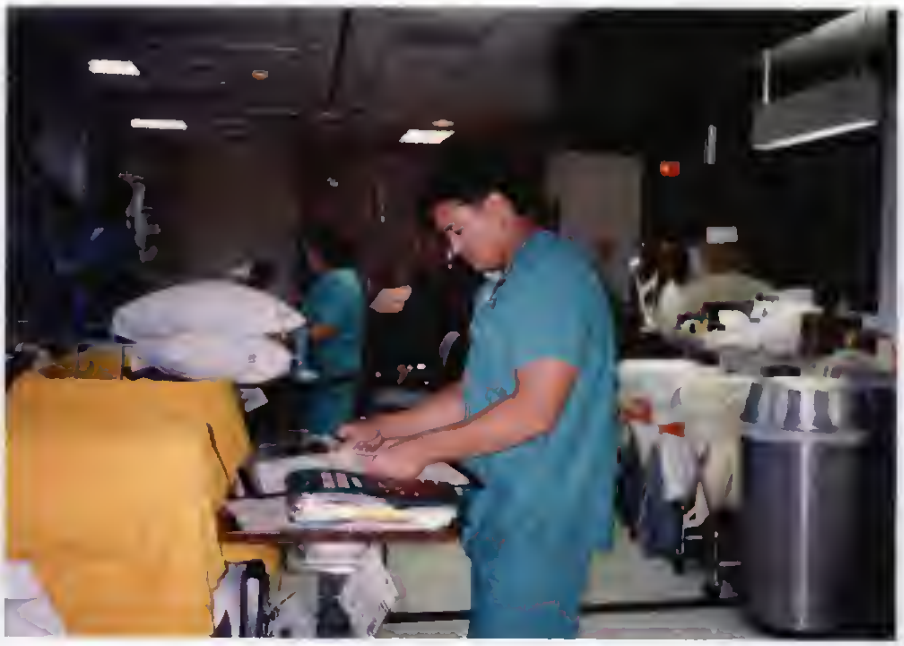

Figure 19. Week Four: Extending the Distance.

Again, orientees shared the advice of preceptors. As an orientee remarked "I'm real glad she hasn't just turned me loose, but I'm also glad that she's turned me loose." Orientees advised for the happy medium of "to know I'm not just in there. That I can act and she's right there to make sure I don't do anything wrong." During this phase, orientees appreciated feedback for "the positive and negative." They also began to value the opportunity to "develop my own style" and to be challenged in their practice with such things as "open ended questions...so you get a good understanding of why something is the way it is."

An Overview of the Four Weeks: A Resemblance to Learning to Ride a Bicycle

The advice from preceptors and orientees over the four week period of data collection related to facilitating the transition of a new nurse can be compared and summarized by envisioning someone teaching another to ride a bicycle. During the initial phase, the teacher demonstrates the skill. The learner

is then placed on the bicycle and begins riding while the teacher holds on for safety and to assist with steering and balance. The learner gains trust as he/she realizes the teacher is there for them and will not let go and put them in danger. As the learner gains confidence and skill, the teacher begins to let go for short periods of time on straight-aways, but travels with the bicycle to be able to grab on if the rider falters. When the rider comes to difficult terrain's such as curves or uneven pavement, the teacher is there to steady the bicycle to keep the rider from falling. Over time, as the rider increases his/her skill, the teacher lets go more and eventually stands back further and further to watch, but is ready to jump in and render assistance if the rider is perceived as getting into danger. The teacher challenges the leamer with more difficult terrain before letting go entirely. Eventually, the skill of the learner improves to the point where the teacher and learner can go on rides together as peers rather than as a teacher and leamer.

This comparison is also applicable since there are no theories that are adequate to explain the practice of bicycle riding, nor the practice of precepting. Both require knowing in the sense of subsidiary awareness (Polanyi, 1958). Through subsidiary awareness we preform activities without fully knowing how we are accomplishing them. The awareness is built on past experiences that form a basis for acting on what feels good and what has worked. Subsidiary awareness guides in attending to the needs of others through tacit actions and reactions.

Summary of the Journey to Independence: Advice from Beginning to End

As a part of their lived experiences, preceptors and orientees were able to give advice about the desired role of preceptors in assisting with the transition of new nurses. During each of the four weeks of interviewing there was agreement between preceptors and orientees in relation to how the role should be enacted.

The advice was focused on moving the orientee from a state of watched, unsafe dependence to a state of safe independence. Over the four week period, preceptors and orientees saw the teacher move further and further from their side while still providing the support and opportunity for help when needed.

First week advice focused on building trust and developing open communication. Trust was enhanced as preceptors recognized knowledge and skills that orientees possessed and built upon them. Orientees, however, advised that preceptors not assume anything and begin their teaching at the basic level. During week two interviews, orientees and preceptors advised that orientees be allowed to do tasks in order to learn. The hands on approach to teaching and learning was viewed as an effective and efficient way to learn. Third week advice centered on lengthening the rope between the preceptor and orientee. By letting orientees do what they could, they began to develop confidence in their role and to gain a sense of what their roles would involve. Preceptors, however, needed to be watchful to ensure safety, to teach unfamiliar skills, and to step in when orientees got behind or became overwhelmed. Advice from fourth week interviews included expanding the orientees' space by giving them as much responsibility as they could handle while still being available to step in.

Summary

Chapters IV, V, VI, and VII contained descriptions of teaching practices that preceptors utilized to teach orientees how to care for patients in their work settings and to assist orientees to transition safely into their new environments. These practices enabled preceptors to balance the demands of caring for patients and teaching simultaneously. Chapter VIII comprises an overview of the study, the relationship of the findings to the literature that formed the basis for the research questions, and the implications of the results to education and research.

CHAPTER VIII
CONCLUSIONS, DISCUSSION AND IMPLICATIONS

This chapter contains an overview of the study, application of findings to research questions, relationship of findings to the literature, discussion and conclusions, implications of findings for future research, and implications of findings for educators.

Overview of the Study

Preceptors are relied upon in most hospital settings to orient nurses to their new work setting. The purpose of this study was to discover the practice of precepting as it occurred from the perspectives of both the preceptor (teacher) and orientee (learner). From the perspective of the teacher, the study sought to describe practices utilized by preceptors to facilitate transition and teach the knowledge and skills needed to work in a new environment. From the perspective of the learner, the study sought to describe what orientees felt were effective practices to help them transition to their new work setting and acquire necessary knowledge and skills. The ultimate goal was to gain an understanding of precepting that could be applied to preceptor training programs and to improve the practice of precepting.

The research study was guided by the following five questions:

1. What teaching/learning experiences do orientees identify that assist role transition and socialization to a new work community?

2. What teaching/learning experiences do orientees identify that assist in development of basic knowledge and skills in a new health care environment?

3. What teaching behaviors and activities do preceptors use to facilitate the learning process of nurse orientees?

4. What strategies do preceptors use to reduce the stress associated with role transition of orientation into a new work environment?

5. How do preceptors simultaneously handle their work and teaching responsibilities?

A qualitative interpretative methodology was used to answer the research questions from the perspectives of both teacher and learner. The methodology included both interview and observation data obtained from still pictures. Data were collected during a six month period in 1994 from eight preceptors and eight orientees. These 16 participants were purposively selected based on eligibility criteria. A total of 62 in-depth, open ended weekly interviews were conducted and 555 pictures taken. During interviews, pictures from the preceding week were displayed for participants and functioned as a reminder for events that had occurred and focused preceptors and orientees on the same events. In addition to interviews and pictures, demographic data were collected related to age, education, and experience.

Ten patterns and associated themes were revealed in this study within three major categories: (a) the teaching domains of precepting, (b) the tact of precepting, and (c) the journey to independence. Patterns and themes were extracted from interview data and authenticated by pictures. All interviews were audio-taped and transcribed using a word processing program. Data were analyzed by reducing, sorting, and categorizing and placed in computer files representing patterns and themes. A list of the ten identified patterns and associated themes is available in Appendix D. Findings were validated by study participants and four doctoral prepared individuals, experienced in qualitative research.

Application of Findings to the Research Questions

The Teaching Domains of Precepting

Research questions two and three were answered by five patterns and themes that were grouped under the category of the teaching domains of precepting: (a) teaching/learning basic skills, (b) teaching/learning about ill-defined, complex, and risky situations, (c) teaching/learning about organization, (d) teaching/learning about salience as a basis for prioritizing, and (e) interpreting the picture. These teaching practices were described by both preceptors and orientees and authenticated by orientees as effective to their learning. While the specific knowledge and skills differed between study units, teaching practices were consistent. A brief description of each pattern follows.

Teaching about basic skills

Teaching orientees about basic skills was an ongoing task for preceptors that occurred at the bedside of patients and involved tasks that required a one time explanation/demonstration, could be repeated with minimal assistance, and required little repetition and follow up. Basic skills comprised segments of direct and indirect patient care and in most situations were related to equipment or procedures. However, basic skills involved both cognitive and psychomotor abilities; the ability to both understand and do the skill.

Teaching basic skills was revealed as a four phase process with each phase grounded in the practice of teaching by talking. Teaching by talking functioned as a means for preceptors to narrate their experiences in the practical context (Britzman, 1991). Dialogue offered in advance of the skill provided a means of conceptualizing and describing and dialogue offered throughout the phases provided prompting, reminding, and evaluating.

During the first phase, preceptors prepared orientees for the task by sharing their experiences through dialogue that explained the how, what, why,

and when of the skill. The advance preparation established rationale for the skill, so that learners could enter the doing phase with a concept of meaning in terms of the patient and/or the role of the nurse. During the second phase, preceptors talked orientees through the skill, providing step by step guidance. By talking orientees through the skill, preceptors could facilitate learning by doing while ensuring safety for patients and orientees. The third phase was characterized by talking that filled in the learning gaps; gaps normally present as one learns and retains a new skill. Talking related to filling in the gaps continued until the preceptor deemed the orientee safe to perform the skill independently. The final phase provided verbal feedback to orientees that encouraged confidence in their abilities and prompted them to attain higher levels of knowledge and skill.

Teaching about ill-defined, complex, and risky situations

Ill-defined, complex, and risky situations were encountered everyday by study participants, however, as the terms imply, were multi-faceted, unpredictable, and hazardous if not handled correctly. Therefore, teaching about handling these situations required repeated teaching and practice over time with prolonged follow-up and supervision. Four practices served as a basis for teaching orientees how to handle ill-defined, complex, and risky situations: teaching by example, teaching cognitive rules, switching places, and debriefing.

Teaching by example was used to teach about situations that were detailed and difficult to explain. Teaching by example was accomplished by letting orientees observe practice with or without thinking aloud. Through watching and sometimes listening to the practice of preceptors, orientees were able to reflect on situations and gain understanding about what was involved. Teaching cognitive rules provided orientees with boundaries of safety. Without rules, inexperienced nurses floundered, unaware of whether situations were safe or unsafe. Rules, provided verbally or through written materials, established

guidelines about what was normal or abnormal. Orientees could compare the rules with patient findings and make determinations about whether actions should be taken. Over time, cognitive rules were tested and adapted with experience.

As orientees gained confidence and ability in situations, preceptors switched places with them and assumed the role of assistants; assistants who promoted orientees to assume responsibility for major aspects of patient care while still being supervised and helped as required or requested. As assistants, preceptors performed tasks that orientees already were comfortable with in order for them to gain experience with skills that were less familiar.

The final practice of debriefing provided orientees an opportunity to discuss and reflect on rapidly changing situations requiring intense involvement. Debriefing was also used to analyze and reflect on happenings that occurred during a shift. By reliving situations, orientees were able to explore what happened, what feelings they had about the situation, and what could have been done differently to improve practice. Reflection *on* actions increased awareness and understanding.

Teaching about organization

The ability to organize work was difficult for inexperienced nurses, yet was considered an important component of the practice of nursing and affected the way nurses were viewed by peers and members of the health care team. To assist with the development of organization skills, preceptors utilized the teaching strategies of list making, dress rehearsal, and checking in with orientees during the day to keep them on track. List making provided orientees with written reminders they could refer to during the working day to remind them about when to do tasks or what they should be doing at any point in time. Dress rehearsals enabled orientees an opportunity to practice in front of the preceptor before performing in the presence of others. Preceptors were afforded time to refine

techniques so that orientees would appear confident and organized. By checking in with orientees at intervals during the day, preceptors had the opportunity to help orientees make decisions about how to organize work so that they would never get too far behind.

Teaching about salience: A basis for establishing priorities

Salience forms a basis for prioritizing actions and enables nurses to make good choices about where to direct their attention. Therefore, having a sense of salience is an essential part of nursing practice and was required to be taught to orientees to help them gain a sense about importance and non-importance. To accomplish this teaching, preceptors utilized talking and teaching by example and challenging. Talking and teaching by example did not differ from earlier descriptions. Challenging involved urging orientees to reach decisions and to explain rationale. Through challenging, preceptors were able to hear orientees think aloud, thus exposing their understanding of situations. By responding to orientees, preceptors were able to validate their thinking, prompt further consideration to arrive at other options, or offer alternative plans based on their knowledge and experience.

Interpreting the Picture

Preceptors also assisted orientees to interpret situations. Without experience, orientees could not see or hear situations with the same understanding as experienced nurses. Preceptors shared their experienced interpretations thereby helping orientees to comprehend with a higher level of understanding.

The Tact of Precepting

Research questions one and four were answered by two patterns and themes under the major category of the tact of precepting. The patterns included: (a) transitioning orientees into a new work environment and (b)

safeguarding the patient and orientee. Again, these teaching practices were described by both preceptors and orientees across study units and were authenticated by orientees as effective. Each of the two patterns and associated themes will be briefly described.

Transitioning orientees into a new work environment

The practices utilized by preceptors to assist orientees to transition into their new work environment resided within the realm of the "tact of teaching" (van Maanen, 1991). Tact is defined as the ability to know what to do in a situation to enrich a learning experience. Teachers use tact to understand situations, interpret meanings, and direct their actions based on understanding and meaning. In this study, preceptors utilized tact to understand what it meant to be an orientee in a new work setting, to realize where orientees were in the learning process, and to plan where they needed to go.

Preceptors gained an understanding of what it meant to be new by remembering their own experiences and by watching, listening, and interpreting the verbal and non-verbal communication from orientees. What they saw and heard formed a basis for their planning in terms of where orientees needed to go, how fast they could tolerate getting there and how much support they required.

Safeguarding the patient and orientee

In hospital settings a narrow margin of error is acceptable within legal and professional standards. The potential for new nurses to function outside this margin is great and therefore, orientees required safeguarding to protect themselves and the patients they served. Preceptors functioned as safeguards by moving in and out of situations to check on, remind, and sometimes rescue orientees. Preceptors based their moving in and out on several considerations including patient acuity, time, where orientees were in the learning process, how well they remembered learning, and the attitude of patients to new learners.

Preceptors gauged the timing for moving in and out by being aware of the environment including what orientees were doing and how they were handling situations.

Checking on orientees was accomplished to ascertain that scheduled and unscheduled work was being done accurately and on time. Checking on was done openly and honestly in the interest of the patient and was viewed by orientees as welcome and helpful. If orientees had not remembered to complete a task or if they were so overwhelmed they had not been able to accomplish the work, preceptors would remind them. By reminding, orientees learned which tasks could be overlooked, delayed, or were so important they needed to be done as scheduled. Thus the act of reminding orientees assisted them in learning salient aspects of situations. The final safeguarding practice revealed in this study was moving in to rescue. Preceptors moved in to rescue patients and/or orientees when orientees had reached their capability limit and were unable to handle situations. Rescuing restored safety and ensured that appropriate actions were taken.

Balancing the Demands of Caregiver with Preceptor

Research question five was answered by the pattern, balancing the demands of caregiver with preceptor, that was situated under the major category, the tact of precepting. Being a teacher and provider of patient care simultaneously was necessary to provide orientees with opportunities for practical learning and to accomplish required work within available resources. In most instances, preceptors were able to meet these demands to their satisfaction and with gratification. The one exception revealed in this study occurred when preceptors were so busy, they did not have adequate time to spend with orientees. This lack of time caused frustration and dissatisfaction.

Preceptors were able to meet the demands of both roles because they were organized, flexible, had a sense of salience about how to establish priorities, were committed to patients and orientees, and were skilled in caring for patients within their unit populations. In addition, they had support from peers and other members of the health care team all of whom created an environment where learning was fostered. Organization and a sense of salience enabled experienced preceptors to plan how they could best function in the dual roles, yet deviate from their plan should unexpected events occur. An embodied commitment to patients and orientees positioned preceptors as responsible agents and advocates who attended to the needs of both.

Additional Findings

Two additional patterns and associated themes were revealed in this study that were placed under the major category, the journey to independence. These patterns included: (a) launching the orientee and (b) the journey to independence: advice from beginning to end. Launching the orientee involved moving the orientee from a state of dependence to a state of independence. The first step in launching was determining when orientees were ready to assume a level of independence. Waiting for the right time demonstrated a concernful practice, characterized by patience, understanding, and trust. When preceptors determined that orientees were ready to be launched, they accompanied them with the support of their verbal and physical presence. Their physical presence offered safety and security and their verbal support offered encouragement and reassurance. Preceptors also functioned as resources during launching, encouraging and answering the many questions that orientees posed. Finally, preceptors provided assistance by doing work that orientees could not handle. This act prevented orientees from getting behind and getting overly frustrated and stressed.

The journey to independence: advice from beginning to end was derived from answers to questions asked at the end of each interview related to what was important for the process of transition. The advice was based on events, feelings, and realizations from the preceding week. Advice from both preceptors and orientees produced week by week insight into what were required to move practice from a dependent, unsafe state to a safe, independence state.

Relationship of Findings to the Literature

The results of this study are related to previous literature in the areas of precepting, learning by experience, and practical knowing. This study adds to the literature in the area of teaching practices used by preceptors which have not previously been described from the perspectives of the teacher and learner. The study also adds to the literature related to learning while doing in an organizational setting.

The practice of precepting is widely used by hospitals and was supported by findings in this study as an effective means for orienting new employees or nurses transferring to a new work setting. Precepting provides new nurses an opportunity to work with experienced staff nurses on a one to one basis to learn the knowledge and skills needed to care for an unfamiliar patient population. Preceptors are prepared for their role through hospital-based training programs which focus on speculated topics thought to prepare nurses for the complex task of teaching, such as adult learning, assessing learning needs, and methods of evaluation (Alspach, 1989a). In contrast, their practice in this study was described as experiential-based and entailed a number of teaching/learning techniques which are not described in the literature. Only one study from the literature described the practices of preceptors for staff nurses (Rittman, 1992) and none were found that examined both teacher and learner perspectives.

This study also contributes the body of knowledge that describes teaching and learning that occurs outside the traditional classroom in the workplace as a complex process that involves the acquisition of practical knowledge. Much of the knowledge of nursing is embedded in practice and, therefore, is experiential and practical (Urden, 1989). Practical knowledge, however, is difficult to understand, teach, and master and there are few guidelines to assist nurses whose role includes this responsibility. Findings from this study are important because preceptors facilitated the acquisition of practical knowing through many practices that have not been previously defined. Many of the practices utilized by preceptors were found to facilitate reflective thinking and to encourage reflection *in* and *on* actions, a mechanism identified to create an effective learning experiences (Schön, 1987).

This research successfully incorporated findings from Benner (1984) who described the role of experience with the development of skill acquisition and professional development in the practice of nursing. This study suggests that experience, at a level where clinical competence and attributes such as organizational skills have been acquired, is necessary in order to role model and teach others about nursing. Further research in this area is recommended.

This study elaborates on literature that describes dialogue as a mechanism for teaching (Daloz, 1986; van Maanen, 1991). Reflective practice is encouraged by having reflective conversations about a situation, framing understanding of the situation based on the experience, trying out actions, and reinterpreting or reframing the situation based on the consequences of action (Marsick & Watkins, 1992, p.9). Dialogue in this study was found to serve as a foundation for teaching practical knowledge and skill and was a predominate practice by itself or was incorporated with other practices.

Discussion and Conclusions

Findings from this interpretative study support the use of precepting as an effective method for orienting nurses to a new work setting. Orientees in this study entered into their new work assignments lacking the knowledge and skills required to care for patients and with feelings and emotions characteristic of those experienced during transitions. Assigning a preceptor for each orientee afforded an opportunity for orientees to learn while being protected in their new environment. Thus the patient, orientee, and organization were protected from mishap and the organization met its obligation to provide for the learning of new employees.

Through this study much was discovered about the practice of preceptors, a practice which has previously not been described, nor understood. The practice blended the roles of nurse and teacher with actions directed to patients and orientees. Preceptors focused their practice around the care of patients and used the bedside and its' surroundings as a learning laboratory. The practice was discovered to be complex with implicit components that were difficult to describe or detail either by the teacher or learner. A concern by the researcher is that findings will be viewed and described as individual components, without an understanding of the totality of the role. It is actually the totality of individual practices that constitutes precepting. Teaching cognitive rules and debriefing are as much a part of the role of precepting as making sense of situations, knowing when to apply practices, and timing practices so that goals can be met. Therefore, precepting, as defined in this study, should be viewed as a holistic, concernful practice developed through a blend of experience and theory.

The practice of precepting, in this study, relied upon clinical competence and teaching practices. This combination was used to assist orientees to apply theory, teach practical knowledge and skills, both of which apply to patient care

situations. None of the preceptor participants described being taught the teaching practices which were discovered in this study. Preceptors were experienced staff nurses who knew what needed to be known and done to care for their patient population. Therefore, they knew what to teach. How they knew how to teach is unknown and is a recommendation for further research.

Much of the success of the practice related to the relationship that developed between the teacher and learner. Preceptors built a relationship that enabled them to teach orientees what they needed to know in a manner that kept them safe, fostered their independence, and recognized and elaborated on the knowledge and skill they already possessed. Orientees, in turn, respected and trusted the clinical practice of their preceptors and recognized that preceptors operated in their best interest and the best interest of the patient. Based on the relationship, orientees viewed being critiqued and evaluated as a professional entity that was a normal part of the learning process.

Organizational variables may have contributed to these study results. The study setting supported the preceptor program by providing regular preceptor training sessions and assigning orientees and preceptors to the same work schedule. Only one orientee was assigned to a preceptor at any one point in time. In most cases, preceptors were given freedom to choose patient assignments and to delegate orientees assignments as a part of their own. Input into decisions about assignments and flexibility in roles have been determined to be important factors in preceptor satisfaction (Shogan, Prior, & Kolski, 1985).

The practice of preceptors was situated around learning by doing or learning through experience (Watkins & Marsick, 1992). Learning through experience is common in organizational settings because people learn what they can apply to their real work. Learning from experience is enhanced by reflection *in* and *on* action (Jarvis, 1992). In this study preceptors promoted reflective

learning through many of their teaching practices including teaching by example, challenging, debriefing, and dress rehearsals. Through these teaching practices, preceptors assisted orientees to think about and make sense of situations in which they were involved. Reflecting on actions is an internal process. However, preceptors described teaching practices that prompted reflection and led to a search for new knowledge, sought alternative ways of thinking, or challenged and questioned one's own beliefs. This led to experimentation with new thoughts or behaviors (Watkins & Marsick, 1992).

Learning from experience in this study departed from the behaviorist paradigm. Precepting was not a pre-designed program but rather a learner-centered experience with a major concern for patients. The ill-defined, complex, and risky situations nurses dealt with had a great deal of variability and presented challenges in which outcomes were not immediately clear. Situations such as these, cannot be handled by theoretical knowledge alone (Schön, 1987). Rather, teaching must be based on personal experiences on how best to facilitate learning in each individual situation and on how the experience is understood by the learner (Marsick, 1987). What orientees learned in school and in their limited clinical experiences did not apply to many work situations described in this study including, communicating with physicians, reporting on patients to oncoming shifts, organizing work, and dealing with unexpected situations such as decreases in blood pressure or chest pain. No formal training could prepare a nurse to handle a situation in which several physicians converged on a patient's bedside, commanding orders and asking questions. Even if these situations had been learned through formal training, dealing with individual situations and solutions would have to be reframed within each organizational setting and within each distinct patient population. In addition, the learning process was not one of simply job-related knowledge and skills but one

which involved interactions with patients, physicians, peers, and families, and a responsibility for maintaining standards for the hospital and profession of nursing.

Therefore, preceptors utilized teaching practices different from formal teaching techniques; practices that were directed to learning how to handle practical work situations. Preceptors individualized teaching by responding to the nature of each task as defined by the learning setting, timing, method, and purpose for learning by experience. Preceptors relied on a combination of their formal learning and experience to teach orientees how to handle situations. Their knowledge and experience with situations over time, formed an understanding and capability which they had found effective and which served as a foundation for what they taught orientees. Preceptors had discovered what worked and what needed to be done and shared their repertoire of successes with orientees as a foundation for their bank of experiences which could be tried and tested over time.

While viewed as a positive force in this study, experience and practical knowledge that do not reflect a high standard could be a limiting factor in the learning process. To avert this possibility, this study substantiates the recommendations of others who define clinical competency as a selection criteria for preceptors (Armitage & Burnard, 1991; Davis & Barham, 1989; Holly, 1992). The minimum level of clinical competence required for precepting was not defined, nor could be found in the literature. Recommendations related to years of experience were cited (Henry & Ensunsa, 1991), however, years of experience may not relate to competency.

In addition to clinical competency, what was defined by this study were practices and strategies preceptors utilized to successfully and effectively perform their dual roles of teacher and caregiver. These practices included organization, flexibility, and the ability to perceive salience about situations in

order to establish priorities for actions. The knowledge used by preceptors is acquired through experience in work settings (Benner, Tanner, & Chelsa, 1992) and were taught to orientees through role modeling and the sharing of personal knowledge. Therefore, in order to be successful at teaching, preceptors needed to have enough experience to have developed salience in their own clinical practice.

The outcome of this study is an understanding of what preceptors did on a day to day basis in order to promote learning by orientees. The interpretative approach utilized in this study facilitated this understanding by providing the researcher with a means to gain access into the lived experiences of orientees and preceptors. By dwelling with preceptors and orientees over time through interviews and pictures, the researcher was able to interpret data that had meaning for teachers and learners. As Heidegger (1927/1962) stated, "It is not we who point to things; rather things show themselves to us." Through interviews and pictures, the practice of precepting which previously had been hidden, manifested itself. The interpretative approach does not dissect nor categorize data but seeks to understand. For the researcher to explain data he/she must first understand the meaning it has from the viewpoint of the subject (Palmer, 1969).

The interpretative approach was effective for this study which sought to understand patterns of teaching and learning that were common across interviews and pictures and representative of everyday practice. By studying transcripts and pictures that depicted experiences from teachers and learners, the researcher was able to capture their point of view. The validity of these interpretations was verified by subjects as truthful, comprehensive, and useful. Thus, understanding was gained through interviews and pictures that resulted in a description of the practice of precepting.

Health care organizations depend on preceptors to orient nurses to their new practice settings in a relatively short period of time. In addition to teaching, preceptors are often assigned responsibility for additional patient care and occasionally to function as charge nurse. The complexity of this assignment demands something in return. In this study, preceptors received only 8-16 hours of preparatory training to meet the demands of a dynamic, complex role that carried dual responsibilities. Preceptor training is based on speculated topics that may or may not apply to responsibility for teaching practical knowledge and skills. Hospitals have a responsibility to adequately prepare preceptors, just as preceptors have the responsibility to prepare orientees. Therefore, training or some form of support should be provided on an ongoing basis and should be based on actual experiences of preceptors who have discovered what works. Finally, the role of precepting should be recognized by health care organizations as an intricate process and preceptors should be recognized and rewarded for the services they provide.

Implications for Research

The findings associated with this interpretative study indicate that further study is warranted in the following areas:

1. Further research using a similar interpretative approach is needed in a multitude of settings to ascertain whether teaching practices are present and consistent across different settings, such as teaching versus non-teaching hospitals, institutional versus non-institutional settings, and specialty care areas such as operating rooms versus more traditional care units. These studies should also take into account differences such as nursing care delivery systems and the way that patient assignments are made.

2. Further investigation of the teaching practices and learning preferences by male and female nurses is needed. Recent feminist studies have suggested

there may be differences in the way men and women teach and learn (Belenky et al., 1986; Gilligan, 1982; Loughlin & Mott, 1992). While teaching and learning should not be gender based, an appreciation for what enriches learning for both men and women would be helpful to all (Loughlin & Mott, 1992). Since this study included only one male learner, such distinctions could not be made.

3. Preceptor participants in this study had previous precepting experience and were highly regarded and respected by head nurses and peers as both preceptors and nurses. However, not all preceptors fall into this category and therefore, further study is needed to define the level of clinical competence and other attributes such as organization required to effectively and efficiently precept. Such research could be accomplished by studying preceptors with varying levels of experience to ascertain what characteristics signaled a minimum level of competency whereby clinical and organizational skills could be taught and role modeled.

4. The discovery of teaching practices utilized by preceptors necessitates further research to ascertain if and how these practices can be taught to others. Discovering practices does not mean that they can be transferred to others, nor that the discovered ways will be helpful to others. "Knowledge is not something we pour from one vessel (teacher) into another (student) (Sorohan, 1993, p. 48). Therefore, research questions need to be answered related to whether and how these practices can by taught in a classroom setting or possibly learned by watching experienced preceptors teach.

5. Further research is also needed related to teaching/learning breakdown. In this study, orientees progressed at what preceptors termed a normal or accelerated rate and no learning difficulties were encountered. However, preceptors related prior experiences where breakdown had occurred. How these situations are handled, what practices impact on outcome, and what

cues preceptors use to decide if and when an orientee will not make it are important areas that impact on resource management.

6. Another recommendation for further research also relates to resource management. This study covered the first four weeks of preceptor/orientee interaction and was chosen because it represented the most intense period of teaching and learning. It was apparent, however, that teaching and learning would continue after the four week period, particularly in intensive care units. Two questions arise in relation to this issue: (a) After the intense teaching/learning period has ended, what type of support do orientees need to advance their skills and practice safely? and (b) What knowledge and skills do orientees still need to learn and have support for after the official orientation period? This study gave some insight into the second question. At the end of the four weeks for this study, it was apparent that rapidly changing situations remained overwhelming for orientees. This is but one example and needs to be expanded upon.

7. Further study is also warranted related to teaching practices effective for nurses with experience. Orientee participants in this study were new graduates or new to an area of practice. Practices that are effective for orienting experienced nurses should be identified and tested for their effectiveness. Outcomes from such studies could serve as a basis for preceptor programs that met the needs of nurses with different levels of experiences and improve the efficiency of programs.

8. A study that links outcomes to practices should be conducted. This study did not extend beyond the intense teaching/learning phase of orientation programs. During the study phase, orientees expressed satisfaction with their preceptors and with the learning program. However, no information was

obtained of whether participants were ultimately able to be productive in their new environments, nor to relate teaching practices with performance.

9. Finally, the methodology used for this study that incorporated both interviews and pictures should be considered for a wide range of qualitative studies in nursing. Taking pictures of nurses teaching and learning and then showing pictures to subjects during interviews enhanced their memory of experiences, caused them to relive feelings and emotions, and generally served as an interview guide. Pictures allowed the investigator to listen, rather than ask questions, which facilitated her ability to concentrate on prompting for elaboration and clarification of teaching/learning activities. Preceptor and orientee subjects enjoyed reviewing the pictures and the combination of relating and seeing their experiences caused them to reflect on happenings.

Implications for Health Education

Although the findings from this study cannot be generalized to other settings, the perspectives of preceptors and orientees discovered in this study provide significant insight into their lived experiences that can be read and tested in other environments. The findings are important because they provide understanding about precepting that have not been known before and therefore, have implications for preceptors, staff development educators, college and university faculty who assign students to preceptors in clinical settings, and organizations that are attempting to gain insight into learning by doing.

1. In addition to the theoretical concepts commonly taught, preceptor training programs should focus on existing, practical teaching practices. Practices such as those described in this study can be brought forth during educational programs by having experienced preceptors relate stories about their practice and tell how they handle different types of teaching situations. In addition, new nurses, who have recently been oriented, could relate their learning

experiences and narrate what was helpful to them. By hearing narratives about lived experiences, inexperienced preceptors could gain insight into the practice of others that can be tried and tested.

2. In addition to training programs to develop new preceptors, hospitals should develop and support ongoing educational programs for all preceptors. This recommendation is based on new understanding about the complexities that form the teaching role of preceptors. The current practice of providing 8 to 16 hours of education to prepare preceptors for teaching diminishes the significance of the role and does not provide enough depth to be beneficial. These ongoing educational programs should focus on the principles of reflection in and on action and on methods such as those discovered in this study that foster reflective thinking.

3. Because of the complexity and demands of precepting, preceptors should have a means for obtaining ongoing support while they are precepting new employees or students. Responsibility for the support could be placed with the staff development department or with other experienced preceptors who may not be actively precepting. Having someone to share experiences with and "bounce" ideas off from would provide a mechanism for preceptors to feel supported in their practice and to gain insight into situations by reflecting on practice.

4. Health care and academic organizations that use preceptors should have a reward system in place that recognizes their contribution. The reward may be as simple as a thank you letter or certificate of recognition. Although this study indicated that preceptors gained internal gratification for contributing to the professional growth of others, external rewards are usually accepted with appreciation as an acknowledgment of their service. This suggestion includes colleges and universities that utilize preceptors for senior students.

5. As a result of the findings of this study, precepting should be recognized as a combination of teaching new employees practical knowledge and skills and assisting with transition. Therefore, preceptor training programs should focus content on both areas. Organizations should review training programs to determine if they emphasize the differentiation between knowing *that* and knowing *how* and the support and assistance orientees need to transition to a new work environment. The bedside and its' surroundings should be recognized as the learning setting with the patient as the focus. The main focus of nursing involves caring for patients, regardless of the setting, and therefore, preceptor programs should revolve on what patient care needs are rather than on organizational and bureaucratic entities. The knowledge of experienced nurses about what patients need should be used as a basis for planning training programs, in addition to their insight of what it means to be new.

Summary

The detailed descriptions of the teaching practices discovered in this study provide hospitals with understanding of the contribution preceptors make to learning and to the effectiveness of the organization in terms of the recruitment and retention of nurses. Organizations, that support similar preceptor programs, can be assured that new employees are placed in protected learning situations that safeguard the new nurse, patient, and organization from harm and form a basis for professional development. The described teaching practices can serve as a basis for preceptor development programs and for further research to determine if findings can be applied to other settings and situations. The preceptors and orientees who participated in this study had much to offer staff developers, other preceptors, and organizations in terms of their ability to define their effective and concernful practice and to validate the effect on learning.

APPENDIX A
INFORMED CONSENT TO PARTICIPATE IN RESEARCH

J. Hillis Miller Health Center
University of Florida
Gainesville, Florida 32610

You are being asked to participate in a research study. This form is designed to provide you with information about this study and to answer any of your questions.

1. TITLE OF RESEARCH STUDY

   An Interpretative Analysis of the Teaching and Learning Aspects of the Practice of Precepting

2. PRINCIPAL INVESTIGATOR

   Mary E. Blazey, R.N., M.S.N. (Work) (904) 376-1611, Ext. 6296
   (Home) (904) 377-1535

3. THE PURPOSE OF THE RESEARCH

   The purpose of this study is to determine how the practice of precepting happens from a teaching and learning perspective.

4. PROCEDURES OF THIS RESEARCH

   When you begin the preceptor program, you will be asked to complete a questionnaire that asks you demographic information and about your education and experience. Twice every day for the first four weeks of your orientation, I will photograph you working on the unit. I will arrive unexpectedly and simply photograph you in whatever activity you are engaged. At the end of each week, for four weeks, I will arrange to interview you about what happened during the week in terms of teaching and learning. During the interview, I will show you the pictures I have taken to remind you about what kinds of activities occurred during the week. We will arrange a time and place convenient to you. I expect the interviews to take about 60 minutes.

   After finishing collecting information and after I have studied the information and reached some conclusions, I will bring my conclusions

back to you and ask you to agree or disagree. Reading the results will probably take about 15 minutes, followed by 15-20 minutes of discussion.

The photographs that I take of you may be used in educational settings and as a part of my doctoral dissertation. While I am working on and after I finish my dissertation, the photographs will be kept securely in my home. If I wish to publish results of this study in professional journals, I will obtain addtional permission from you to publish pictures in the journals.

5. POTENTIAL RISKS OR DISCOMFORT

There are no known potential risks.

6. POTENTIAL BENEFITS TO YOU OR TO OTHERS

By sharing your experiences during the precepting program, you will contribute to an understanding about how precepting actually occurs from a teaching and learning standpoint. This information may be used in training preceptors and may contribute to making the orientation transition for new nurses more meaningful and less stressful.

7. ALTERNATIVE TREATMENTS OF PROCEDURES, IF APPLICABLE

The alternative is not to participate in the study. You may withdraw from the study at any time.

11. General Conditions

You understand that you are free to withdraw your consent and discontinue participation in this research study at any time without this decision affecting your medical care. If you have any question regarding your rights as a subject, you may phone the IRB office at (904) 392-3063.

In the unlikely event of you sustaining a physical or psychological injury which is proximately caused by this study:

__X__ professional medical; or

____ professional dental; or

____ professional consultative

care received at the J. Hillis Miller Health Center will be provided without charge. ***However, hospital expenses will have to be paid by you or your insurance provider***. You will not have to pay hospital expenses if you are being treated at the Veterans Administration Medical Center (VAMC) and sustain a physical injury during participation in VAMC-approved studies. It is understood that no form of compensation exists other than those described in section 8 of this informed consent.

I also understand that the University of Florida and the Veterans Administration Medical Center will protect the confidentiality of my records to the extent provided by Law. The Study Sponsor, Food and Drug Administration or the Institutional Review Board have the legal right to review my records.

12. Signatures

The Principal or Co-Principal Investigator or representative has fully explained to

_____
(Subject's Name or representative)

the nature and purpose of the above-described procedure and the benefits and risks that are involved in this research protocol. The Principal or Co-Principal Investigator or representative has answered and will answer all questions to the best of his or her ability. The Principal or Co-Principal Investigator may be contacted at telephone number 904-376-1611, ext. 6296

_____ _____
Signature of Principal or Co-Principal Investigator or representative Obtaining Consent — Date

With your signature you certify that you understand the statements in the consent document and are satisfied with the explanation, including the possible benefits and risks, as provided by the investigator or representative and the consent process. You have given permission for your participation in this study.

_____ _____
Signature of Patient or Subject (Includes children 7 to 17yrs of age) — Date

or

_____ _____
Name of Subject's representative Date:

If you are representing the patient or subject, please check your relationship to the patient or subject:

_____ The subject's parent or guardian

_____ A surrogate

_____ A durable power of attorney

_____ A proxy

_____ Other, please explain:

_____ _____
Signature of Witness Date

Appendix B
Demographic Data Instrument

Preceptorship ID Number: _____

1. Preceptor: _____ Orientee _____

2. Gender: Male ___ Female ___

3. Age: _____

4. Basic nursing education:
   ___ Diploma Year Graduated _____
   ___ ADN Year Graduated _____
   ___ BSN Year Graduated _____

5. Other nursing/nonnursing degrees abtained beyond initial program:
   ___ ADN Year Graduated _____
   ___ BSN Year Graduated _____
   ___ MSN Year Graduated _____
   Other: _____
   _____

6. Total experience in nursing? _____years, _____months

7. Total experience in area where currently assigned? ___years, ___months

8. For preceptors:

a. Did you receive preceptor training? ___Yes ___ No

   1. Date of training? _____

   2. Length of training? _____

   3. Topics included in training? _____
      _____
      _____
      _____
      _____

b. Approximately how many nurses have you precepted? _____

c. Approximately how frequently do you precept? _____

For orientees:

a. Have you been oriented with a preceptor before: ___ Yes ___ No

   1. How many times? _____

   2. What were the lengths of the programs? _____

APPENDIX C
CONSENT FOR USE OF PICTURE AND/OR VOICE

Department of Veterans Affairs

VETERANS ADMINISTRATION

CONSENT FOR USE OF PICTURE AND/OR VOICE

CONSENT OF *(Name)*

NOTE The information requested on this form is solicited under the authority of title 38, United States Code. The execution of this form does not authorize disclosure of the materials specified below except for the purpose(s) stated. The specified material may be used within the VA for authorized purposes, such as for education of VA personnel or for VA research activities. It may also be disclosed outside the VA as permitted by law. If the material is part of a VA system of records, it may be disclosed outside the VA as stated in the 'Routine Uses' in the "VA Privacy Act Systems of Records "published in the Federal Register. A copy of the 'Routine Uses' is available upon request to the administrative office of the VA facility involved.

You do not have to consent to have your picture or voice taken, recorded, or used. Your refusal to grant your consent will have no effect on any VA benefits to which you may be entitled.

I hereby voluntarily and without compensation authorize pictures and/or voice recording(s) to be made of me *(or of the above-named individual if the individual is legally unable to give consent)* by *(specify the name of the VA facility, newspaper, magazine, television station, etc.).*

While I am *(describe the activity, if any to be photographed or recorded)*

A patient at the Gainesville VA Medical Center

I authorize disclosure of the picture and/or voice recording to *(specify name and address of the organization, agency, or individual(s) to whom the release is to be made)*

Mary E. Blazey, R.N., Graduate student at the University of Florida

College of Educational Media/Instructional Design

I understand that the said picture(s) and/or voice recording(s) is intended for the following purpose(s)

To be used in a doctoral dissertation that focuses on the teaching and learning of orienting nurses

I have read and understand the foregoing and I consent to the use of my picture and/or voice as specified for the above-described purpose(s). I further understand that no royalty, fee or other compensation of any character shall become payable to me by the United States for the use of my picture and/or voice.

(SIGNATURE OF INDIVIDUAL OR OTHER LEGALLY AUTHORIZED PERSON) (DATE)

INTERVIEW AND PERMISSION OBTAINED BY *(Name • title • address)*

(SIGNATURE OF INTERVIEWER) (DATE)

PRODUCTION TITLE

PRODUCTION NO.

IMPRINT PATIENT PLATE OR WRITE IN INDIVIDUAL'S NAME & ADDRESS

IMPORTANT: This form must always be completed prior to the making or using pictures and ½ or voice recording(s) of any individual. If that individual has any history of drug abuse, alcoholism or sickle cell anemia or infection with the human immunodeficiency virus, an additional VA Form 10-5345 is required prior to the release of any data to any source.

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APPENDIX D
PATTERNS AND THEMES

The Teaching Domains of Precepting

Teaching Basic Skills
- Preparing the orientee for doing
- Guiding the orientee through the skill the first time
- Filling in the learning gaps
- Evaluating through feedback

Teaching about Ill-Defined, Complex, and Risky Situations
- Teaching by example
- Providing cognitive rules
- Switching places
- Debriefing

Teaching about Organization
- Writing guidelines
- Dress rehearsals
- Touching base

Teaching about Salience: A Basis for Prioritizing
- Teaching by example
- Challenging

Interpreting the Picture

The Tact of Precepting

Transitioning Orientees into a New Work Environment
- Acquiring a perspective of being new
- Moving orientees forward
- Planning

Safeguarding the Patient and Orientee
- Gauging the boundaries of practice
- Gauging when to move in and out
- Checking on
- Reminding
- Rescuing

Balancing the Demands of Caregiver with Teacher
- Attributes for success
- The role of the environment

The Journey to Independence

The Launching Process
- Readiness to launch
- Support during launching
- Assisting to regain control

The Journey to Independence: Advice from Beginning to End
- Coming to know and trust
- Supporting and letting do
- Being open and available
- Extending the distance

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BIOGRAPHICAL SKETCH

Mary Recktenwald Blazey was born on July 30, 1941, in Rochester, NY. She received a diploma in nursing from St. Joseph's Hospital School of Nursing, Elmira, NY, in 1961. In 1980, she received a Bachelor of Science in Nursing from the New York State Regents Degree Program and in 1985, she received a masters degree in nursing from the University of Florida.

Since graduation in 1961, Mrs. Blazey has practiced nursing in a variety of settings including medical-surgical, school health, geriatric, and critical care. Mrs. Blazey has always been either directly or indirectly involved in the education of nurses, and in 1986, she became the Associate Chief, Nursing Service for Education at the Gainesville Veterans Affairs Medical Center. While in this position, she became interested in the practice of precepting. Mrs. Blazey plans to continue in her present position to apply the knowledge she has obtained. She also plans to conduct research that expands her dissertation research and to apply the interpretative approach to other facets of nursing.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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